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CONTENTS

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RACE RELATIONS *

CULTURAL AIDS TO CONSTRUCTIVE RACE RELATIONS

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THAT the problem of race prejudice is a challenge to educators, we take for granted. That those who take up the cudgels against racial prejudice will agree as to its cause and its solution, is by no means so certain. It is common practice on the part of reformers to assume that the existence of race bias is a pathological defect of the American mind. If this is so, then we in this country are all pathological. For race prejudice is one of our widespread folkways. Our culture sanctions it.[1] Most of our children begin to learn it in one form or another from the minute they can sit up at the family dinner table.

On the other hand, we have a cultural heritage, which we also spout, if not at the dinner table, then as soon as we go to school—"This is a free country!" This is the heritage of thought that we call the democratic ideal—or what Gunnar Myrdal in *An American Dilemma*[2] calls "the American Creed." He refers to that group of ideals which stem from the Declaration of Independence, the Constitution, and Christianity—that is, the ideals of "liberty," "equality," "justice," and the "brotherhood of man."

Where, then, is the pathological defect? Does it not lie in

* Presented as part of the program of the Thirty-fifth Annual Meeting of The National Committee for Mental Hygiene, New York City, November 9, 1944.

[1] See "Concerning Race Prejudice," by Scudder Mekeel. *American Journal of Orthopsychiatry*, Vol. 14, pp. 699–705, October, 1944.

[2] New York: Harper and Brothers, 1944.

the discrepancy between the ideals of our cultural heritage and the cultural behavior and attitudes that are actually learned?

Those of us who do not regard prejudice as abnormal try to condone it on the basis that it is "human nature" to have biases against minority groups. The argument runs: "We have prejudices, but we also have the American Creed. Should not our ideals be sufficient to control our racial prejudices? Therefore," we say, "there must be something in us human beings that makes us prejudiced." This is both a dangerous and an unwarranted assumption. We have only to look at other cultures to see that any such assumption is false. Let us glance at Brazil and Russia, countries that are frequently held up as shining examples of freedom from prejudice.

A good study of the interracial situation in Brazil was made by Donald Pierson and published in his book, *Negroes in Brazil.*[1] The study is confined to the seaport town of Bahia, so that we have a detailed picture of an actual Brazilian community in operation. Pierson describes the well-defined class system, usual for Latin-American countries. Almost all the black Negroes are in the lower class; though a very few are in the upper, slightly more are in a group marginal to both the lower and the upper. In Bahia, there is no middle class, as we know it. The whites predominate in the upper class, with some in the marginal group and a very few in the lower. In other words, *color and class tend to coincide.*

Pierson shows, however, that social status depends on class position, rather than on skin color. First of all, the class system is in no sense a caste organization. It may be pointed out that a bi-racial society becomes caste-organized when marriage is prohibited between the two racial groups. A caste society also prohibits marriages between classes. In Brazil neither interracial nor inter-class marriages are banned. A person about to marry presumably thinks not so much of the race as of the class of his fiancée. In other words, he would hesitate far more about a girl's belonging to a class below him than he would about the degree of her race mixture. Secondly, a black Negro, with education, ability, and

[1] Chicago: University of Chicago Press, 1942.

knowledge of the social graces, can and does rise in social status. Some rise to the top.

Racial discrimination, therefore, appears to be at a minimum in Brazil. Negroes are rising in status. As in the United States, they started at the bottom of the social heap. In the United States, too, the Negroes are gradually bettering their position. There is, however, a tremendous difference between the two countries. In Brazil those Negroes who rise do so within a *single class system composed of the total society* and without regard to race. In the United States, on the other hand, the Negroes have their own class hierarchy, separate from the white. Interracial marriage is prohibited by custom everywhere in this country and enforced by law in many of the states. Hence we have a caste system reënforced by various forms of segregation. These are outstanding facts of difference between the two countries. So, in Brazil race prejudice as we know it in the United States does not exist. This is a cultural fact, a fact that can be explained in cultural terms, not in terms of quality of human nature.

It would be fortunate if we could leave Brazil at this point. A social scientist, however, cannot ignore certain other facts that Pierson mentions. One striking piece of evidence is that blackness of skin ordinarily is a mark of inferior social status. However, if a particular black person bears such symbols of higher status as those expressed in dress and general manner, he is accorded the higher status. Correspondingly, light skin color carries prestige. Thus there is a desire to marry "light"—that is, to marry a person considerably lighter than one's self. Some of the folk expressions reveal shame at being black. The Bahian people do not ordinarily use the term Negro, except in anger, as an insult—or, interestingly enough, in the term "my Negro," or "my little Negro," as a term of endearment even to a white woman. These facts reveal a derogatory, but paternalistic attitude toward Negroid traits.

Before we leave Brazil, we might for a moment acknowledge the certainly better race relations in that country as contrasted with ours, and even go so far as to agree with Pierson that class is more important than race. But how about the *class* situation there in terms of decent human relations? The gap between the rich and the poor is exceedingly wide. Lower-

class Bahians express their discontent largely in class or economic rather than in racial terms. I mention this aspect only because I firmly believe that we shall have to examine race relations against the perspective of human relations generally, or we shall go astray in any study of mere race relations as ordinarily conceived. Bahia is a relatively quiet community, reflecting a paternalistic "plantation" structure, with little apparent conflict or competition. What would happen to the racial situation there if Brazil were industrialized? This is not an idle question, for such countries as are just now starting industrialization.

Let us now turn to the Soviet Union. Under the imperial Russian régime there was racial and group prejudice, especially against Jews. The imperial government actually encouraged Jewish prejudice and persecution. There also existed discriminatory practices against the dependent national groups within Greater Russia.

The revolutionary government decreed by fiat that prejudice and discriminatory practices should henceforth cease. Much of what we know about the Union of Socialist Soviet Republics comes from sources biased for or against the régime. For that reason it is difficult to know what the situation really is. We do know the official stand of the government and the fact that the dependent national groups have been able to use their languages in the schools and that these national groups have in fact real cultural autonomy.

It is conceivable that the fiat against prejudice may really have taken deep effect. To begin with, the hostility once expressed in prejudice has now had a new outlet in hostility against the kulaks and the economic middlemen who stuck to their old pursuits. Perhaps such a direction for hostility was aided by the fact that some Jews happened to be in these very occupations. More important, there was the tremendous constructive job of remaking old Russia and industrializing the country. All available man power was needed. There was no desperate competition for jobs. The aggressive urges of the people could be harnessed to the challenging goals set by the government—goals in which the people were made to feel that they had a personal stake. Prejudice after the revolution had, therefore, very little to feed on.

Then, too, the granting of cultural autonomy to minority groups and submerged nationalities was a definitely planned policy. It was not a sentimental program, cherishing esoteric ways for their antiquarian quality. The revolutionary government profited from the experience of the imperial Russian government. The imperial government, for instance, had met resistance from dependent peoples, whenever it directly attacked a native language. The result was to perpetuate exactly what the imperial government had wanted to destroy. The revolutionary government, by granting cultural autonomy, lessened the resistance of the people. It could then the more easily introduce the new economic system essential to the success of the revolution.

Every indication points to the success with which the Soviets have been able to eradicate race prejudice as such. The old class structure has, of course, been destroyed. But instead of a Marxian "classless" society, new classes are forming on a different basis from the old. Classes may well be inevitable in complex societies. There must be some hierarchy of control. This does not mean that there has to be economic exploitation, social discrimination, unequal opportunity, and rigid hereditary class lines. Russia, since 1940, seems to have entered a critical period in which the new class system has begun to crystallize.[1] What the results may be is not yet clear.

With Brazil and Russia as examples, we can say that race prejudice is not inherent in the human animal. If we want to be more cautious, we can say that if there is any human tendency to recognize and acknowledge differences, cultures can control the uses to which such recognition is put. The recent studies of human conditioning in various cultures have shown how plastic the human animal is. Man is usually trained from birth to assume his rôle in life as an adult. That rôle varies tremendously from culture to culture and often involves control or suppression of some native tendencies. Therefore, by modifying our cultural patterns, we can confidently expect a change in our racial attitudes. But the real question is, "How do we modify these culture patterns?"

[1] See "Vertical Social Mobility in Communist Society," by N. S. Timasheff. *American Journal of Sociology*, Vol. 50, pp. 9–21, July, 1944.

An American looks to education when he wants to effect a change. Education is a powerful tool, but we often forget that it is only one part of our culture. It cannot carry the whole load in any significant change in attitude. The use of law is another technique we like to think of, particularly if we despair of accomplishing anything by education. But, again, law is only one aspect of a culture. To be effective, a law needs the good will and support of the majority—as we found to our bitter cost during the prohibition era.

At those points where we desire to make changes in a cultural pattern of our society, we must use the knowledge we have of cultural process.[1] What we need desperately is an applied social science that combines our understanding of human personality under varying cultural influences with what we know about cultural change. Too often we still ask whether race prejudice can be attacked by appeal to the churches, or by discussions in the schools, or by documentary films, prepared for wide circulation. We should be asking: By what factors does racial prejudice as a cultural pattern become intensified, modified, or eradicated? We must take into consideration the particular personality structures imposed on individuals by our culture, and the particular forces in our society that arouse both anxiety and hostility. What we need to do is not to "reform" individuals, A, B, and C, in regard to their prejudices and discriminatory behavior. We need to deflect, modify, or transform the processes at work in our society so that children will no longer learn, nor their elders sanction, prejudice and discrimina-

[1] See *Man and Society in an Age of Reconstruction: Studies in Modern Social Structure*, by Karl Mannheim (New York: Harcourt, Brace, and Company, 1940), particularly the following passage: ". . . there is an important development in the power to influence mankind, when instead of some form of inculcation, we choose a form of influence where society itself, through its patterns and relationships, urges an individual to alter his behavior. Far too extensive use is made of direct methods of inculcation, such as browbeating, suggestion, emotional appeals, preaching, agitation, and even education in the older sense of the word. These are very often merely provisional solutions adopted by a society which has not had the opportunity of using indirect methods of social influence as a means of training." See also Margaret Mead's *The Problem of Changing Food Habits*, pp. 20–29 of a report, with the same title, of the Committee on Food Habits of the National Research Council (Bulletin 108, October, 1943). As executive secretary of the committee, Margaret Mead took a similar position in regard to the problem of changing food habits in this country.

tion. It is just as important that in doing so no equally injurious outlet is substituted in place of the old.

Recently, wide publicity has been given the so-called "Springfield plan." The public-school system in Springfield, Massachusetts, has made a concerted effort toward creating better understanding among the various groups in the city. The published reports have mentioned the classroom projects and the coöperation of such adult groups as the Parent-Teacher Association. This is a splendid and laudable attempt. The plan has undoubtedly relieved general tensions, and it should have wider use elsewhere. From the angle of cultural change, however, what we would like to know about Springfield are such things as whether changes have taken place in the dinner-table conversations of the parents about persons belonging to minority groups; whether the traditional stereotypes about minority groups have begun to break down in favor of reality; whether there has been a decrease in taunting remarks made by children of one group to children of another; whether there have been regroupings of children on the playground or in walking to and from school—regroupings that cut significantly across racial or religious lines. Such indications as these would be crucial in estimating the extent of success of the Springfield plan in terms of fundamental change.

We might as well face the fact that we would not still continue to have race prejudice and discrimination unless they accomplished something for us. The first thing to find out is what we gain by these patterns. If there were not some gain, the American creed of liberty and equality would be the controlling mechanism of our inter-group behavior, instead of merely a mildly restraining influence.

The gain is largely psychological in nature. It comes from the use of race prejudice as an outlet for otherwise free and floating anxiety and hostility. We can track down much of such hostility and anxiety to particular factors operating in our culture. Basically, these factors arise in the process of character formation which bears indelibly the stamp of our culture.

Hostility and anxiety are further aggravated by certain social and economic conditions inherent in our particular

culture. For instance, we know that our society is highly competitive. The feverish struggle produces anxieties. Keeping any sector of the population from better jobs lessens competition and, therefore, lessens anxiety for the majority group. Race discrimination, especially against the Negro, has been found to accomplish this decrease in anxiety. To bar Negroes from better jobs immediately removes 10 per cent of the total population from potential competition. Anxiety in itself arouses hostility that needs expression. Race prejudice provides a useful outlet.

The anxieties and hostilities that arise from the way in which we are socialized, particularly in this culture, are deeper and more fundamental than those aroused by the external conditions under which we live. By the way in which we are socialized our character is formed. The resulting product of the conditioning process, in so far as it affects all of us, we refer to as the *personality structure.* The structure of personality varies a great deal from culture to culture. There are also, of course, individual variations. But the stamp of our particular culture is on all of us.

Personality structure in the United States varies according to locale, region, and class. These variations reflect the fact that our culture is not homogeneous. We can, however, safely posit a few tendencies identifiable as typically American. As between regional and class differences, those of class seem the more decisive in personality formation. If we want to find the power house for racial prejudice, we shall have to spot those sectors of the population that have the most to gain by the expression of hostility. In order to do this, we should have to look at class structure in America, as well as at the regional variation in culture. A planned attack on prejudice will have to take these differences into account by separate, but coördinated plans for each particular region and every class within it.

A direct attack on these problems often arouses resistance in the very people whom one is trying to influence. A fundamental change will come only through indirect means that undercut the sources of prejudice. The cradle is the best place to start. If efforts were made to ease the modifications of the impulse life we impose at a deep level in the growing

child, there would be no such great need for outlets of deflected hostiility. We cannot make these changes in the name of race prejudice alone. For as a matter of fact, more would happen than a mere change in racial attitudes. For example, if we can raise children who are more free in their expression, we may have less neurotic adults, provided there is an integrated culture for these children to fit into. There is, of course, a limit to the range of behavior within any society. There must be some mutual expectancy in the behavior of individuals in any specified social context. This is the essence of social structure.

In our American culture, the limits to behavior are narrowly imposed by our strict child-training methods. True enough, individualism is one of our ideals. But we can afford to risk our social structure on such an ideal. For by the very way in which we train our children, we make certain that they can never really carry individualism very far, or take full advantage of being themselves. This is the crux of our particular system of social control. We must, then, be wary of going too far in our relaxation on child training until we see where we want to go in terms of the social structure we believe we should have. Whether our aim is to reduce race prejudice or to produce less neurotic adults, the changes should be in terms of "better child care," rather than in terms of the more specific objectives.

Child training is not the only necessary point of attack. Any concerted move toward an economy of abundance would lessen pressure to remove any particular group from job competition. Economic scarcity and lack of job opportunities are not by any means *causes* of race prejudice, as the Marxists would have us believe. Economic factors are a *stimulant* to the expression of prejudice.

Active use of race prejudice in this country is definitely associated with reactionary, illiberal, and conservative thinking on social, economic, and political subjects. The association is not fortuitous. It seems to be based on an inflexible personality constellation of the individual who for some reason, social or personal, is insecure and whose normal expression of aggression is blocked from constructive outlets. In other words, the coupling of race prejudice and

fascist ideology is not a creation of the Nazis, but a potential ready to be played upon. Therefore, any liberalizing movement or any shift toward reaction should correspondingly affect the status of prejudice in this country.

Unless other factors are introduced into the situation, we may well see in this country after the war a period of reaction and organized outbursts of prejudice in the name of nationalism. Signs of such a shift are already appearing. Anxieties are already mounting as to whether there will be jobs for all after the war. There is an increasing fear of Negro competition on account of the economic gains Negroes have made during the war. Jewish prejudice has been increasing in certain parts of the country. Even now before the end of the war, there are demagogues who are only too ready to lead the band wagon. Hostile impulses continue to rise in the free-for-all, and race prejudice stands a ready outlet.

In the face of mounting reaction and prejudice, we must not lose sight of the long pull. We must turn to the dynamic forces within society itself to reduce race prejudice and the other undesirable factors associated with it. The values necessary to a harmonious society cannot be arbitrarily determined by social scientists, and then handed out on a silver platter as a recipe for a "brave new world." This is not within the competence of science. However, on the basis of the known components of cultures and on the basis of personality structures formed by such cultures, we could arrive at general conclusions as to the range of values in keeping with the aspirations of the peoples of the Western world. It would then become clear at what points there could be common understanding with the peoples living under the various Eastern cultures. Each culture may have its own design for living, but all must have certain basic understandings and goals in common.

No treaty of peace, no agreement among nations, is going to solve the basic problem of how we are all going to live together. Pacts on paper, however well constructed they are, cannot by fiat change our animosities, our blind drives for power, our tendency to form into societies, each of which feels superior to all the others. Only recently have we begun

to appreciate and to understand the forces at work. We must tap these forces in human personality and put them to work in an altered cultural setting. The whole problem of reconstituting cultures—reconstituting the whole basis upon which we live—makes the particular problem of race prejudice seem small indeed. It is only through a forceful attack on the total problem of our living together that we are going to be able to solve permanently such problems as race prejudice which are parts of a larger whole.

Meanwhile, we must live by the imperfect knowledge we have. There are plenty of things we can do. We can work for a child training of which the goal is a more complete and plastic personality. We can take more seriously our responsibilities as citizens. We fail to realize that when this Republic was established, it was set up to be run by the property-holders, who had the franchise. They in turn took upon themselves an obligation to protect the common citizen in the rights guaranteed to all in the Constitution. There is now in control no such class with a high moral purpose. The potential control has passed to the people at large. In other words, we have moved toward a mass democracy in which it is the responsibility of each one of us to protect the rights guaranteed to all of us without regard to race, creed, or color. As long as we are apathetic about our responsibilities, just so long will special and selfish interests be able to wield actual control to the detriment of large sectors of our population. With the exception of the few remaining poll-tax states, we the people hold the franchise—but we do not have economic democracy. Anything that we can do to work toward economic security will lessen the tensions of race prejudice.

For the immediate emergency of the after-war reaction and a possible wave of rising prejudice, we must take short-term measures immediately. We should publicize the dangers to the public peace and to the rights of certain of our citizens in the formation of hate organizations parading falsely in the name of nationalism. To see that the creation of such organizations, or the revival in full force of the Ku Klux Klan, is imminent, we have only to look at our history. Within the last hundred years, there have been

three nation-wide organizations that threatened our internal peace and security—the Know Nothings in the decade preceding the Civil War, the American Protective Association before the Spanish-American War, and the second Ku Klux Klan after the First World War. The spearhead of the first two was anti-Catholicism, an unfortunate early American heritage that is still with us. The spearhead of the third—that is, the second Ku Klux Klan—was, and is, triple-pronged—anti-Catholic, anti-Negro, and anti-Jew.

The Negroes made economic gains during the last war. This fact was used by the Klan, particularly in the South, to get recruits to put the Negro back in his place. During the 1890's and 1900's, there was a heavy Jewish immigration owing to increasing prejudice in Europe and specifically owing to the pogroms in eastern Europe. The twentieth-century Klan played up fear and hate of Jews, particularly along the northeastern seaboard where most of the Jews settled. Hatred of Catholics was stirred wherever there were Protestants, especially those of the Fundamentalist and strongly evangelical sects. The prejudices unfortunately are still with us. So are the free and floating anxieties and hostilities which can be poured into the mold of prejudice.[1]

Another fact is apparent in the three organizations mentioned. Each one has been stronger than the last and has been able to attract more adherents. So far we have not had a hate and super-nationalist organization that combined with prejudice a definite ideology to apply to government. However, the world trend of such prejudice movements, as we see in Germany, is to embody an ideology. We may get such a development here the next time. It will not be called fascism, because that term is in disrepute. But the tendencies toward reaction, of course, are much older than the word. Since race prejudice and illiberal ideas are closely associated, we could not get any other type of ideology than one which would uphold the *status quo*.

The world is now too small for reaction and prejudice.

[1] A fourth target may be added after the present war—the Japanese-American. There are relatively few of them. However, they are becoming scattered over the United States and the men fighting in the Pacific theatre will return with a virulent hatred of the Japanese. It may be made use of.

What we do among ourselves has repercussions on the rest of the world. Those of us who are white are having, and so far wasting, our last chance to be accepted on an equal basis with the other peoples of a world that is two-thirds colored. The three-hundred-year advantage we have had through the Industrial Revolution is coming to a close as the remainder of the world becomes industrialized and capable of producing modern weapons of war.

There are plenty of men of good will in this country. But there is also much complacency and apathy. We must find a way to arouse people to take an active interest in achieving the kind of world in which we can live in peace and security from want and fear—a world in which we would be free to develop to our full capacities. In such a world there would be no room for race prejudice.

THE FRUSTRATIONS OF BEING A MEMBER OF A MINORITY GROUP: WHAT DOES IT DO TO THE INDIVIDUAL AND TO HIS RELATIONSHIPS WITH OTHER PEOPLE?

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THE minority problem is one of the most significant and far-reaching group-relationship problems facing the American people. Perhaps in no other single aspect of our national living does the concept of democracy fall so short of its reality goal. Professional and practitioner groups, who are daily involved in the processes of helping individuals and groups reach their maximum integration and usefulness, cannot afford to ignore the implications of minority status. This is especially true since most of us are in leadership positions in our agencies, our schools, or our local communities. We hope to illustrate throughout this paper the significant rôle that the leadership principle can play in making for an intelligent approach and reaction to problems raised by minority status.

The minority problem is placed in its most bold relief in relation to the three large racial groups in our culture. These are the Negro and the Jew in all geographic areas, and the Mexican people especially on the West Coast. Can we think together of all three of these groups, with particular emphasis on the Negro people? It is here that the cast and class differences are most sharply drawn. The Negro as a minority, and as a poor and suppressed minority, stands at the peak of the minority spiral. Gunnar Myrdal, the Swedish scholar, in his classic study, *An American Dilemma*,[1] writes in his introduction to Volume I:

> "To the great majority of white Americans the Negro problem has distinctly negative connotations. It suggests something difficult to settle and equally difficult to leave alone. It is embarrassing. It makes for moral uneasiness. The very presence of the Negro in America . . . represents to the ordinary white man in the North as well as in the South an anomaly in the very structure of American society. To many this takes on the proportion of a menace. . . . A few see the problem as a challenge to statesmanship. To all it is trouble."

Myrdal is emphatically and unquestionably right. To be a Negro in our culture is not only trouble to white America—it is trouble, suffering, and, on occasions, hysterical bewilderment to black America. Here is created the setting in which frustrations become a continuous and never-ending reality. Anxiety, fear, and disappointment, confusion, conflict, and not infrequently terror are inevitable by-products of the Negro's minority status, as he strives to be a Negro and at the same time to be a participating American. Thirteen million of our citizens—one out of every ten Americans—have been relegated to the position of second-class citizenship, hardly, if ever, accepted as equals and continuously treated with contempt, scorn, hostility, or indifference. Those of us here know how, in generalized and specific ways, these negative group attitudes affect any individual as he struggles to make an adequate adjustment to his reality situation. We shall attempt to suggest to you how thirteen million Americans feel when the intolerance of minority status is their reality heritage from birth unto death.

One of the most devastating frustrations that plague the Negro is the majority concept that the Negro people are

[1] New York: Harper and Brothers, 1944.

inferior; that always they remain infantile or childlike; that their smiling, happy faces are but conclusive evidence that they are not capable of seriousness of purpose or of sustained intellectual participation. This concept is shared by millions of white Americans despite the fact that voluminous scientific data have made it perfectly clear that the structure of men's bodies is for all practical purposes the same everywhere, that the difference between groups is in their culture, their social heritage. People behave differently as children or as adults because their cultures are different. They are born into different habitual ways of life, and these they must follow because they have no alternative. All of us know the terrific impact that constant repetition has upon the psyche. How many times have most of us discussed with parents the negative implications of always saying that their Johnny or their Mary is bad, is dumb or no good. The Negro is born into a culture that stubbornly refuses to accept him as an equal. Custom and tradition force the majority concept of his inferiority into his consciousness and keep it there.

Let us next consider the frustrations involved in the process of never being allowed to be one's self, never daring to be a person in one's own distinct uniqueness and individuality. This concept grows out of the reality principle that no Negro in America is ever completely unaware of the biological fact that he is a Negro. To illustrate this concept, we need but refer to two group-relationship situations. Negroes when in contact, casual or prolonged, with other Negroes, invariably turn the conversation to a discussion of race, its implications and methods of solving the problem, either through individual or through collective action. When Negroes are in the company of white persons, the conscious awkwardness, the studied carefulness, the restraint, the unconscious tones and undertones—all these are a constant reminder to the Negro that he is a Negro and that his status is that of a dispossessed minority. Imagine, if you will, the tremendous emotional energy expended in the process of never being able to be unaware of one's self. Imagine, if you can, the tragedy of the diffused and dissipated energy that is lost in the process of having constantly to think of one's designated and specifically limiting minority rôle.

The most all-pervading sense of frustration that literally engulfs the Negro people is their caste relationship to the majority group and the mechanisms of segregation and discrimination that are its attendant counterparts. Caste as here used is most vividly and dramatically illustrated by Dollard and Davis in their illuminating scientific study, *Children in Bondage.* Caste is meant to refer to systems of privilege and the limiting of spontaneous participation in the culture of which the Negro people are a part. This caste relationship directly or indirectly affects every single incident of the Negro's day-by-day existence.

To illustrate, we must briefly refer to the historical past. The Negro was brought to America as property and as a slave, to swell the landowner's purse. He was kept as property and as a slave for considerably more than two hundred years, for the same reason—namely, profit. Civil War in the United States caused slavery, as an instrument of profit, to crumble and fall. At that point, the "color-caste" concept became entwined in the consciousness of white America. The social implements of segregation and discrimination became the tools of reinforcing and sustaining the caste relationship. Caste, segregation, and discrimination, as they apply to the Negro people, seem thus rooted in the tradition of economic exploitation. These social situations create the pathological poverty of the Negro people. They render them impotent, when acting alone, to free themselves from these binding fetters.

The typical American town has its black ghetto—almost always situated on "the other side of the railroad track." Our big American cities have their Harlems, South Sides, and Beale Streets. Life is rough and hard in the ghetto. It is difficult to stay there and more difficult to leave. Overcrowding and congestion become commonplace. Individual privacy and eventually the respect for it disappear. As to employment, the picture is even more dire. The oft-repeated phrase that the Negro is "the last to be hired and the first to be fired" unfortunately continues to be true. Even when employed, the majority are relegated to the most menial, unskilled, and short-duration jobs. Income, therefore, is not

[1] Washington, D. C.: The American Council on Education, 1940.

only low, but irregular. Living becomes a drab, dull day-to-day existence with little or no security for the future.

It was caste and its limiting segregation and discrimination mechanisms that caused Bigger Thomas in Richard Wright's famous novel and play, *Native Son*,[1] to exclaim:

> "Every time I think about it, I feel like somebody's poking red-hot iron down my throat. Look! we live here and they live there. We black and they white. They got things and we ain't. They do things and we can't. It's just like living in jail. Half the time I feel like I'm on the outside of the world peeping in through a knot-hole in the fence."

These are the limiting and restricting implications of caste. They are as real to the Negro people as are birth, life, and death.

A recital of America's treatment of its Negro minority is not a pretty story. The frustrations here described have deep and serious implications for the Negro and for all of us. Such symptomatic behavior as is shown in unlawful aggression or mental illness on the one hand, or placid acquiescence, boredom, or irresponsibility on the other, is frequently the subtle result of the destructive influences of the emotionally damaging burden of being forced to carry the minority rôle.

What are the implications for professional and practitioner groups in relation to this web of frustration and the negative and symptomatic behavior that these frustrations inspire? The first and most direct implication would seem to be that we ourselves should explore and reëxamine our own conception of and fundamental attitude toward minority groups. Few, if any, of us escape association with minority peoples. Many are in contact in a professional sense. We cannot but fail utterly in a teaching, diagnostic, or treatment rôle if we, as individuals, foster or give sanction to situations in which these frustratons are allowed free play.

As stated earlier, many of us are in leadership positions. There is an opportunity in the leadership setting not only to help redefine the minority rôle, but also to contribute immeasurably toward the reëducation of those whom we lead —reëducation in the direction of a more rational, intelligent, and enlightened approach to these basic human problems.

My total life experience as a Negro and more especially my

[1] New York: Harper and Brothers, 1940.

present position in a leadership rôle—as Executive Director of the Wiltwyck School for Boys—has crystallized for me the positive validity for creating, for all human beings, a living situation in which culturally conceived and culturally sustaining frustrations do not exist.

At the Wiltwyck School for Boys considerable time and attention have been devoted to the development and maintenance of a group-living situation in which alleged delinquent and emotionally disturbed children might find understanding and warmth rather than aggresson and hostility; an atmosphere in which the adult response to the child would be one of genuine acceptance rather than of indifference or neglect; a setting in which the child would be able "to dare to be himself" and a person; an environment in which every child would take advantage of his right to an audience or to be heard, regarding any or all of his real or imaginary hurts or complaints. In essence, the effort has been in the direction of creating a setting in which the most basic and generally accepted mental-hygiene concepts (regarding positive personal relationships and their interaction) might be exploited in the interests of emotionally ill and disturbed children.

The school has a significantly large percentage of its population composed of children who are so ill as to be candidates for commitment to a state hospital. The warmth and spontaneity of the school atmosphere and the day-to-day casual and treatment contacts with the staff make for apparent transformations in the child's personality and the kind and quality of his total response.

In September, 1944, the Wiltwyck School was surveyed by the New York State Department of Social Welfare. The study was an effort to determine to what extent the school was meeting the individual needs of the children under care. We quote from the submitted report [1]:

> "The program at Wiltwyck has one outstanding characteristic. Every child is accepted as he comes to the School. He is free to express himself without inhibition. Staff members are trained to recognize and absorb the disturbed boy's aggression and to meet that aggression with understanding. The importance of relationship is constantly stressed in the treatment of the child who in most instances has been seriously damaged by parental attitudes and community reaction to his behavior."

[1] Unpublished.

In another section of the report, we find the statement:

> "One of the most conclusive evidences of the inherent soundness of the staff-child relationships at Wiltwyck is the absence of any problem regarding runaways. Less than ten children have absconded in the past year. No child has attempted to run away since May of this year. . . . The impression gained during the survey was that children are essentially happy at Wiltwyck, while they are learning the art of growing up both physically and emotionally."

We see an obvious parallel between the treatment and care afforded the children at Wiltwyck and the long overdue unmet needs of the Negro people, needs that grow out of the frustrations inherent in the minority rôle. What does the Negro ask? What does he want? Are there special privileges involved? In a word, he wants to experience democracy. He wants to be regarded as a person and not as a social category. He wants freedom and peace; an enriched life that will bring an absence of want, oppression, and hostility. He wants the opportunity "to live as humanity" and to experience the real satisfaction of participating in our glorious culture as a free individual and as an equal.

NON-DISCRIMINATORY HOSPITAL SERVICE

HARRY C. OPPENHEIMER
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OUR chairman's introduction has identified me to you as a layman who is vitally interested in the new interracial hospital at Sydenham, at 124th Street and Manhattan Avenue, New York City.

Sydenham is the first interracial hospital in the United States, and for this reason, the organizing staff has been particularly aware of the basic attitudes among the workers and the patients of the hospital. These people are principally from the Negro and the white races, though we have also among our personnel a Chinese research man and a Japanese receptionist. The hospital is planned for all races, but the neighborhood location brings to us mostly Negroes and white people.

I am going to devote my talk to those aspects of the hos-

pital which seem particularly pertinent to this conference—namely, the wholesome attitudes that we have encountered all along the way among the people of different races in our work. I will discuss four groups: first, the staff; second, the patients; third, the families and friends who visit our patients; and fourth, the outside public.

It is conceded that there is no color line among very young children. It is also conceded that there is no color line among adults who are absorbed in work to the point of intense and self-effacing concentration. It is no wonder, then, that among doctors of different races, working together on scientific research and ministering to sick patients in emergencies, there is a minimum of consciousness of racial difference. This condition applies also to the nurses, who supplement the work of the doctors in close association, as well as to the technicians, the laboratory workers, and the other hospital personnel.

At the present time the hospital medical staff and personnel are as follows:

Department	*Negroes*	*Whites*
Housekeeping	16	25
Dietary	19	15
Laundry	7	6
Engineering	3	18
Laboratory	1	8
Out-patient	1	5
Graduate nurses	31	25
Non-graduate nurses	7	5
Volunteers and nurses' aids	12	120
Medical staff	23	255*
Interns	2	10
Board of trustees	6	17

* Of this number, 120 are serving in the Armed Forces.

But these same doctors and nurses, when once out of the absorbing atmosphere of the operating room, the sick room, and the laboratory, revert to the everyday social relationships of average people. We were encouraged far beyond expectation when we saw how this mutual social association worked out. We have one dining room for all workers and several recreation rooms on the same basis. It is these social relationships that have been particularly gratifying to us. As Mrs. Roosevelt said on her recent visit to Sydenham, "Social equality to me is what you have among friends. I can't see

how you can legislate about that. I think when you have all the other rights of citizenship, certain social discrimination, to which I am opposed, will disappear." It is this personal friendship that is made possible at Sydenham by bringing people of various races together in an environment in which they can come really to know one another. And the environment has produced just this.

So far, I have mentioned only the attitudes of the doctors and the nurses, who have the advantage of sharing absorbing work. What about the patients, many of them at a low ebb of personality integration, because of sickness and anxiety? Certainly sick people are not at their best. How do these sick people meet the Sydenham environment of interracial healing? The answer is that so far our experience has been as favorable among our patients as among our staff. Through a combination of natural compassion, absorbing interest in their work, and wise indoctrination, our staff give patients a fine reception. And this good start is as contagious as some of the germs that we encounter.

May I be historic for a few moments and tell how the plan of indoctrination developed? On December 20, 1943, when six Negro and six white trustees were added to the existing Sydenham board of nine trustees, we, the interracial group, had a hospital. Every move since then has been trail-blazing and intently watched. We were convinced that a proper approach toward the staff, professional and lay, should be our first step, and this we took by addressing two full meetings on the two following days. Arthur Jones, of the Greater New York Fund, was our principal moderator. We asked only those to remain with us who were willing to give this new interracial experiment their wholehearted interest. Only five people resigned—two nurses and three other workers.

Our next consideration concerned the distribution of patients. The semi-private rooms were our chief concern; the wards had always been interracial. We have averaged 80 per cent of Negro and 20 per cent of white patients in the wards. We knew that the new Negro doctors would be acceptable to these patients. The private rooms were of small concern to us because of their individual occupancy.

For the reception of patients into our twenty-four semi-

private rooms, which accommodate sixty-three people, we made the following plan. We were determined that in these rooms we would make every effort to bring about interracial association without provoking prejudice. We did this in a straightforward, simple way. When a Negro or a white person was ready to be assigned to a semi-private room, the nurse was instructed to tell him that this room already accommodated from one to three patients of other races. If the incoming patient was prejudiced, the nurse was instructed to explain our plan and to ask the patient for a trial period of coöpertaion. So far, not a single patient has raised any objection.

We have definitely made a point of putting colored and white people together rather than having one semi-private room occupied by colored and one by white. We found that after the first day, the two races were just as intimate with one another and exchanged confidences as if they were all Negro or all white.

So much for the staff and the patients. How about the families and friends who visit our patients, and how about the response of the outside public that has come to know about Sydenham through the newspapers and other publicity organs? The families and friends of patients have often made their acquaintance with us in a state of anxiety for the well-being of their dear ones, but these visitors have, without exception, expressed appreciation of the effect of the coöperative, interracial environment upon their sick. Every week we receive expressions of encouragement from these visitors who see our plan work out.

But among our outside public, there is one group that disagrees with us. I would like you to understand that this disagreement is a matter of policy and not a reaction of prejudice. The variant viewpoint comes from an important group and must be faced. The National Association for the Advancement of Colored People, headed by Walter White, believes that it is better to work toward the admission of Negro doctors to the staffs of *every* existing hospital in New York.

The Sydenham organization also believes in such a plan, but we feel that it can best be accomplished by a joint pro-

gram. The interracial hospital seems to us a necessary first step toward the admission of Negro doctors to existing hospitals. Our short experience has already proven that our combined program produces this result.

We have already succeeded, we believe through the efforts of our organization committee for an interracial hospital in Harlem, in having doctors admitted to three leading hospitals in the city—the Hospital for Joint Diseases, Mt. Sinai Hospital, and Brooklyn Hospital. Negotiations are now going on with other hospitals for the admittance of Negro doctors to their staffs.

The objectives and principles of the organization committee for the interracial voluntary hospital were as follows:

Objectives

"1. To work for the fuller integration of Negro physicians, nurses, and other technical workers into the staffs of existing public and voluntary hospitals in New York City.

"2. To establish an interracial voluntary hospital in the Harlem area."

Principles

"1. These two objectives shall simultaneously be pursued with equal vigor and shall supplement each other in the work of this committee.

"2. The interracial principle shall be interpreted to mean that the facilities of the hospital shall be open to all races, creeds, and colors.

"3. An interracial board of trustees shall be the governing authority of the hospital.

"4. An interracial medical staff, consisting of carefully selected physicians and surgeons shall control the medical policies of the hospital."

Our organization has met with the National Association for the Advancement of Colored People and we have thoroughly discussed our difference of opinion. Without animosity, we have decided to disagree for the present. So far we have seen no evidence of their fear of Jim Crowism.

The outside public has written to us from all walks of life, from all states of the Union, assuring us of the need and growth of our enterprise. I should like to quote from two of these messages from the outside. The first is from the late Senator Norris, whom I came to know personally the year I worked in Washington on the O.P.A.

"Sydenham is, as the literature explains, somewhat of an experiment, but it is an experiment that I think is long overdue and the outcome will be of great interest to people who want to do justice to the Negro and want to do it in such a way that it will bring about a more full understanding and coöperation between the two races."

The second is from an unknown mother-to-be, from another state, who wrote one of the most touching letters that we have received.

> "Dear Sirs: I read the article in *The Post* about your hospital. It interests me very much.
>
> "I am going to have a baby in January and I would like to know if I could have it in your hospital.
>
> "My sole stipulation would be that I be put in a room with at least one Negro mother and a Negro nurse.
>
> "My somewhat strange request is because I have lately had a great sorrow and I know that my confinement will be a difficult one, mentally speaking. I feel, therefore, that it would help if I could somewhat submerge my own personal problem beneath the larger one of race relations and perhaps be able to do my very small bit of choosing a hospital with such healthy ideals.
>
> "If you could take me, please send me the prices for a semi-private room."

This is the first expression we have received which suggests that there may be an unforeseen incentive to getting well in getting well together. It may be that the assertion by convalescent patients that they believe in interracial coöperation will help them recover because they are participating in a great interracial plan. They may also be stimulated by the experience of coming to know one another and realizing one another's contributions.

One day last week, I stopped to listen to a song that came to me from one of the wards. A young boy, with a voice that might some day develop to the quality of Paul Robeson's, was singing a spiritual alone—*All God's Chillun Got a Robe.* When he began the second verse, all the patients in the ward joined in. Some knew the words, others just hummed along in quiet accompaniment. I listened to the significance of the words they were voicing in unison—"All God's chillun got wings." This is the spirit of Sydenham!

PSYCHIATRY AND INDUSTRY*

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IN the spring of 1944, a group of ten physicians who practice psychiatry in New York City accepted the invitation of Mrs. Anna Rosenberg and the local headquarters of the United States Employment Service of the War Manpower Commission to join their staff in a study of problems of placement in industry. The immediate goal was to see what help psychiatry could bring to the solution of difficult placement problems.

Each psychiatrist worked with a group of between twenty and thirty interviewers. Case seminars were held, in which an interviewer presented the information that was available on a particular job applicant—to wit, a biographical summary, a job summary, and as much factual data as could be obtained as to the nature of the applicant's contacts with fellow employees, with bosses, and with the employment interviewers. This data was used as the basis for a general discussion by the counselors, the psychiatrist acting as moderator, summarizing the findings, and giving his own impressions as to the nature of the psychopathological problem that underlay the employment difficulty.

One must say "impression" rather than "diagnosis," because the applicant himself was never seen by the psychiatrist, and because the data had not been assembled by a

* For helpful criticisms and suggestions, grateful acknowledgement is due to Mrs. Anna Rosenberg, Regional Director, War Manpower Commission; Miss Ann Lehman, Senior Employment Consultant for the Handicapped, United States Employment Service, War Manpower Commission; Mr. Richard C. Brockway, Chief of Division of Placement, War Manpower Commission; Mr. Herbert Feis, economist; Mr. Anthony W. Smith, C.I.O.; Mr. Leo Huberman, Director, Education and Publicity Relations, National Maritime Union; Dr. Sydney Margolin; and to the nine physicians who collaborated with the author in this undertaking: Dr. Viola W. Bernard, Dr. I. T. Broadwin, Dr. Emeline P. Hayward, Dr. Olga Knopf, Dr. Bela Mittelmann, Dr. Z. Rita Parker, Dr. Nathaniel Ross, Dr. Dudley D. Shoenfeld, and Dr. Bettina Warburg.

staff trained in the gathering of psychiatric histories. Consequently, although some records were remarkably informative, in others there were significant gaps. This depended partly on difficulty in approaching the individual applicant, and partly upon the native acumen and previous training of the interviewer. Despite these limitations, a fairly dependable impression could usually be reached; and the psychiatric evaluation of the applicant often clarified what had otherwise been a perplexing riddle.

One found many schizoid personalities, many depressive equivalents, many phobias, a few outspokenly psychotic and paranoid persons, a number of mixed conversion states, psychopathic behavior disorders of various kinds, and occasional hypomanic states. In short, one ran the gamut of the unrecognized, untreated, ambulatory psychopathology of our population.

It soon became clear that differences in the nature or severity of the psychopathology divided the applicants into four general groups. One group could be cured if treatment facilities could be made available. In another, even with no attempt to cure their neuroses, the applicants could be successfully placed by finding special job situations for them, in which their neurotic needs and fears would not be unmanageably stimulated. It became evident that, for this particular group, the formulation of general rules to guide interviewers and counselors in the placement of applicants with different types of neurotic difficulty was a matter of great practical importance. A third group were so sick that they could be employed only in some form of sheltered workshop; and a fourth were too sick to be employable at all.

These two last groups seriously impeded the work of the agency by taking up a disproportionate share of the time of the workers, particularly as such applicants turned up again and again. Furthermore, these unemployables disturbed the relationship of the agency to industry, because when such applicants were sent out repeatedly, personnel officers tended to lose confidence in the agency's recommendations.

The work is to continue; but in the meantime these preliminary experiences have led us to attempt to formulate in

a general way some of the principles that underlie the relationship of psychiatry to employment problems. We are presenting this in the hope that it will lead to further work in the field.

In any practical application of psychiatry to sociological problems, several allied disciplines must be utilized: to wit, clinical psychology for psychometric tests and aptitude evaluations, employment counseling, psychiatric social service, and many aspects of education. Separately, each of these can do only part of the job; together, they can make a major contribution to the problems of employment in industry. Yet if this is to happen, the allied scientific and sociological disciplines must develop a better integrated relationship to one another, and the code of industry with respect to its responsibility toward industrial man power must change.

The war has taught that certain types of work, certain forms of risk, certain aspects of responsibility and discipline are all potent forces in making and breaking men's spirits. It has taught, further, that one man may thrive on another man's poison. All of this is equally, if less dramatically, true in the industries of peace. If society recognizes the full implications of this, then a consideration of the quality of human life must take its place beside cost-accounting at the council tables of industry.

At this council table, psychiatry and its allied disciplines can make several contributions: (1) by screening out those who are totally unemployable and providing for their shelter, care, and treatment; (2) by allocating to specially chosen tasks, or to sheltered workshops, those who can remain well only under special working conditions; (3) by evaluating individuals both as to their special technical aptitudes, and as to their special personality quirks, and by allocating them to jobs for which their aptitudes fit them, and which are at the same time consonant with their personalities; (4) by applying therapeutic principles to the individual worker who is maladjusted and by using therapeutic principles within the industrial setting; (5) by using social-service procedures to assist workers in coping with those out-of-plant problems which affect both their total psychological adjustment and their plant efficiency; (6) by studying the incidence

of neurotic disturbances in different types of work, and under different working conditions *(e.g.,* the effects of hours of work per day and per week, of the two-day week-end as compared to the mid-week holiday, of speed-up systems, and so on); (7) by comparing the efficacy of different systems of job training, and so forth.

Undoubtedly, many other ways of applying psychiatry to problems of labor in industry will develop as experience grows. Whether either management or labor will welcome the help thus offered will depend partly on the way in which such a service is established, but even more on how the recommendations of the psychiatrist affect the vested interests of each group, under varying conditions in industry as a whole, and in the labor market in particular.

Our next task, therefore, is to consider how a psychiatric service in industry must be set up, if it is to be accepted both by labor and by management, and if it is to persist through fluctuating economic conditions.

In the first place, it is clearly essential that the representatives of the psychological sciences should be in a position the impartiality of which can never be questioned. They must be like the expert who is retained by a court, rather than the expert whose testimony is hired by one side of a legal controversy. Therefore, they should never be employed either by labor or by management. They should function, rather, under the auspices of some body whose disinterestedness is generally accepted, such as a joint labor and management council, with joint financial support and joint supervision. Alternatively, they might function under the auspices of a local, state, or federal labor-relations board.

In the second place, all potential objections of organized labor must be taken into account. For instance, certain older unions bear the scars of old struggles with "company doctors" whom they suspected, justly or unjustly, of using medical examinations as an excuse to get rid of union organizers and union members. The coöperation of such old-timers in labor activities can be won only by placing beyond any possible doubt the impartiality of the psychological and psychiatric group.

Furthermore, workers and unions in general tend to prize

highly the principle of seniority. Under this principle, length of service gives an employee an increasing certainty of tenure of his position; and any procedure, however scientific, that cuts across this principle will inevitably engender opposition. If an individual laborer has a high seniority rating in one department, and if it should be found that in the course of the years he has become ill-adapted for the work that he is doing, whereas he could work happily and effectively in another department, it would be impossible to persuade the man of the wisdom of making such a change, unless his seniority status could be protected. Furthermore, since he had always looked to his union to protect his seniority, any union that espoused a scientific procedure which jeopardized seniority ratings might soon face rebellion in its ranks. These objections can be met only by organizing in such a way that indicated changes can be made without endangering seniority rights, and by first convincing union leaders and their members that in the long run proper placement and early psychiatric advice and help are worth more to them than any absolute inflexibility in the application of the seniority principle.

On the side of management, we face the fact that the attitude of employers toward any such innovations as this will vary with conditions in the labor market. Under conditions of full employment, when jobs are plentiful and labor is scarce, and when the job must hunt the man, management will be eager to salvage every possible laborer, to shuffle men about so as to fit them into jobs where they are most effective and to supply them with all the care that is necessary in order to help them to function as productively and as healthily as possible. Under these conditions, there will be no incentive to misuse the psychological disciplines simply as a means of getting rid of "inferior" workers.

On the other hand, when there is any degree of unemployment, when the man must hunt the job, when the competitive struggle grows sharp between different concerns in the same industries, when narrow margins of profit force individual concerns to a close scrutiny of costs, then inevitably the attitude of management must become quite different. Employers of those types of labor which do not require extensive experi-

ence or training will at such times have much less objection to an active turnover of labor. They will find the rough-and-ready, trial-and-error method of employment more economical than any elaborate method of evaluation and classification. Thus, in general when many job-hunters are available, industry has less incentive to be patient with those workers who need laborious steps of reëducation, retraining, and emotional rehabilitation; and the interest of an individual employer in the psychological disciplines will tend to narrow down to those devices which can function as a watchman at the door to screen out those he does not want. A large labor surplus outside each plant creates stability within the plant; and all the employer needs is some one to relieve him of the less desirable workman.

Employers with a sense of civic responsibility deplore such an attitude; but since profits are the catalysts of industry, a trend in this direction becomes inevitable whenever jobs are scarce, and before undertaking to organize a psychiatric service for industrial and employment problems, the psychiatrist and his psychological allies must weigh carefully such facts as these. They make it obvious, for instance, that any plan that is adequate for a period of full employment would be likely quickly to fall into disuse during periods of unemployment. Therefore, it is of prime importance so to plan the utilization of the psychological disciplines in industry as to give them at least a chance of persisting through periods of economic contraction as well as periods of economic expansion.

Many ways of approaching this goal might be considered. A tentative suggestion to this end can be made. In the first place, as already indicated, conflicting interests such as these can be reconciled only if such services are made the joint responsibility either of a whole community or of an entire industry. At any time an individual concern can set up a pilot test of such a service; but the service is not likely to endure long if it remains the individual responsibility of an individual plant. If, on the other hand, it is the responsibility of an entire industry or community, it has a fair chance of survival.

It would then be possible in a small community to set up

a center in which all industrial operations and processes that are carried on in that particular community would be represented. In larger communities, there would have to be more than one such center. Alternatively, if it was organized on an industry basis, then each industry could set up such cross-sectional centers at key points throughout the country for the industry as a whole.

These centers could perform, either for the community or for the industry that set them up, the functions that replacement training centers and redistribution centers serve in the armed forces—that is to say, they could be portals of intake at which new men were evaluated both as to craft aptitudes and as to emotional quirks; and they could be used for the retraining, reëvaluating, reclassification, and reassignment of men.

As far as each individual is concerned, the use of such centers would be voluntary; but their existence would mean that for men who had lost their jobs, whether because of ill-health, absenteeism (the AWOLs of civilian life), poor performance, or because of changing economic conditions, an opportunity would be available to find out both what they were best fitted to do under the new economic conditions, and what to do about past difficulties, before undertaking a new haphazard job placement. It is conceivable that sheltered workshops could be set up as accessories to these cross-sectional centers, to serve as neurosis-treatment centers for more individual psychotherapy where this is needed.

If labor and management are ever to develop an adequate over-all psychiatric and psychological service in the employment field, then it would seem that pilot tests of some such scheme as this should be undertaken, both in typical industries and in typical industrial communities.

"YOU CAN DRIVE A HORSE TO WATER——" *

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THE old adage from which the title of this paper was taken seems to me appropriate to a discussion of personnel relationships in industry. The concentration on the drives in industry during the past decades is due for a reëvaluation, particularly in view of the multiple problems that face industry in the post-war period.

It is not my purpose here to wave the banner of psychiatry; I should prefer to speak as one practical man to another, seeking ways and means of applying in industry the principles of psychiatry, through developing an approach to the problems of personnel relationships based on an understanding of human nature and human personality.

I was myself a pioneer in industrial medicine, and in 1915 I became the first psychiatrist to venture into industry when I went with the Cheney Silk Company on a full-time basis, and eventually became their personnel manager. During that time, we established the fact that psychoneuroses and emotional attitudes on the part of employees toward their employment, their foremen, their fellow workers, and the machines in the great textile industry were responsible for a greater loss in dollars and cents than accidents and contagion.

In 1922, my contemporary, Dr. Elmer E. Southard, of Harvard University, in the course of a survey sponsored by the Engineering Foundation, found that 62 per cent of the cases observed reached the discharge status through traits of social incompetence rather than through occupational incompetence. Dr. Southard's conclusions, like my own, were that "what might be termed dissatisfaction, both on the part of the employer and the employee, arose not from the employee's

* Presented at a session on "Mental Hygiene and Personnel Relations" at the Eleventh Annual Meeting of the Texas Society for Mental Hygiene, Houston, March 2, 1944.

inherent inability to do the work, but rather from his failure to adjust himself to the conditions under which he was to work."

These are but two examples of early research in industry that have been carried on for the past thirty years, and the final findings all agree on this point: You can teach a man to operate a machine, you can give him good working conditions, you can give him security in his job—*but* it is the man's own emotional drives that determine whether the man will become a real success from his own standpoint.

Thus, if we are practical, we must study the factors that will develop a man's emotional drive to the end that he may be a coöperative member of a producing team. We must face realistically the fact that both management and labor share the problems of production-for-profit; and since the employee serves the employer in order that the employer may better serve industry, the well-adjusted employee pays dividends.

Workers, like all other human beings, have psychological and social, as well as economic, needs; and the worker who is most profitable to himself and to industry is the one who finds in his work a means of self-expression and a satisfaction of his needs for group relationships. If you din into a man that he is unimportant and that his contribution is ineffectual, he will become irresponsible; if you overinflate his ego, he will "swell up like a poisoned pup" and become a nuisance. The real problem—and this is the key to all constructive thinking—the real problem is to make a man feel as important *as he really is* by making him as important as he is capable of being.

To the extent that a man feels *essential,* he will become a responsible and productive citizen and worker. The great function of psychiatry in industry is to point the way more directly toward the realization of this goal. I have no intention to-night of presenting you with a treatise on psychotherapeutics. Diagnostic techniques—or what is popularly called "the best ways of spotting the screwballs"—and the whole subject of neurological organic disorders, psychoses, neuroses, and maladjustments are subjects for the consideration of your industrial doctors. But I do intend to outline those broader considerations of policy which will grow

out of an industrial philosophy that takes into account the human drives fundamental to mental health in any industrial organization.

It *is* necessary, however, to define clearly the functions of the psychiatrist or the medical man who heads the medical department of an industrial organization. In the interests of a sound program of mental health, he should be first of all a *doctor,* maintaining zealously at all times the confidential doctor-patient relationship with all members of the organization. He should be only secondly an officer of the company. When the reverse is true, industry has only a medical technician, doing an obvious technician's job. The real profit to industry comes from the service of a *doctor,* whose professional standards and ethics are respected and taken for granted both by management and by workers.

The physician in industry, who should possess a psychiatric point of view, must have two main functions. One is administration in the matter of placement—and here it may be well to utter a word of caution that he must be careful not to become a "medical policeman," whose job is merely "to keep the screwballs out," for in that case it may become a game with prospective workers "to fool the nut pick." Again in connection with placement, he has the all-important function of seeing to it that no man is placed on a job that is injurious to his health or beyond his physical or mental capacities.

To repeat, the function of the medical man in industry in connection with placement is not that of a medical policeman, but of assisting a man to get a job he really can do; of protecting the health, life, and limb of those already on the pay roll; and of preventing any new employees from bringing contagion into the plant and thereby menacing the health of those about him.

When the workers know that the various health examinations, routine check-ups, and frequent medical reviews are for their own protection—as in the case that the man working next to them on the assembly line might have something "catching"—they will back up the doctor's program with respect and coöperation. But the doctor must be the friend and not the disciplinarian.

If the man in industry with a psychiatric point of view has

avoided the pitfall of being regarded as a medical policeman in the employ of the management, and has maintained the confidential patient-doctor relationship, he will have a golden opportunity to serve the worker, to serve the management, and to serve the industry as a whole through the psychiatric point of view.

I am inclined to believe that it is unnecessary to present this psychiatric point of view as something separate and apart from the rest of industrial medicine and of employment practice, as only too often a man will run from a psychiatric consultation which he will welcome under another label. If the industrial medical man will bear this in mind, he will be able to observe and to diagnose neuropsychiatric symptoms without arousing suspicion, resentment, or alarm.

The purpose of psychiatry in industry is "to clear the tracks" for active, vigorous enjoyment of the job to be done, in the interests of maximum efficiency and minimum loss; it is certainly not its purpose to bandy about the terminology of psychiatry to the point where the entire personnel is bent on psychoanalyzing their inmost thoughts. If that happened, we should have something to worry about! Let our psychiatric services emanate from the doctor-patient relationships, and let us be wary of establishing an attitude whereby the worker takes time from the assembly line to go in for a good cry on the psychiatrist's shoulder in order to ease an emotional problem.

This kind of set-up in industrial psychiatry is too near paternalism to make me feel comfortable; for I am strongly "agin" paternalism in business, or government, or anywhere else except in the home, and then only up to adulthood. Paternalism is bad both for worker and for management, because it is against the inherent dignity of man. I am not against bigger and better holidays, or against bigger and better things for everybody. But I have reached the conclusion—from a not inconsiderable experience—that we are actually living in a world of struggle; and if we acknowledge that fact, we must also acknowledge certain fundamental premises in human relationships.

One of those premises involves the idea that life is not a bed of roses. It is a kind of game—and a tough one at that.

There are people who consider it to be a game like bridge, played in a comfortable parlor in which the players nod to each other amiably, saying, "May I play a heart, partner?" To which they receive the response, "Pray do."

Most of us realize, however, that life is more like a football game, and that we are liable to get a boot where the back forms a sort of mound, and be commanded to get up into the line and carry the ball! And I doubt whether any group of people have taken the hurdles of life better than those raised on "football techniques"; certainly, few have enjoyed the game more. So I believe that we should train our people to survive in a world of struggle, and not overprotect them to the point where we deprive them of the strength that is their rightful heritage, and that can be gained only through the development of moral, intellectual, and social muscles.

Actually, there is no fundamental difference between dealing with children and dealing with adults; both must be given a chance to stand on their own feet and to fight their own battles. For that reason, if for no other, industry should keep out of the private emotional problems of employees. When such problems do arise with individual workers, they should be handled on a man-to-man basis through an individual approach—never as an organizational policy, or through an employer's bureau.

If the emotional problem is related to the job, or has a specific relationship to other workers or to the industry, it is the job of the management to delve into the circumstances and find the cure. But if the problem arises out of community or domestic relationships, industry would do well not to step in except on invitation from the worker, and then only on an unofficial and co-worker basis, advising and helping as a good citizen of the community might advise and help another good citizen. In other words, dealing with the emotional problems that arise out of community or domestic relationship should not be considered by the employer as a formal function of industry.

Industry must get away from all "welfare aura." No one can buy a man's emotions with welfare work. Attempts to do so are like trying to bring up children on a lollypop-reward basis—they will all want bigger and better lollypops. This

does not imply that industry should ignore the basic drives of a man for the psychological and social factors necessary to a productive life which I mentioned earlier; it means that the things that have to be done should be so handled that men will better understand the members of their "team," and will be enabled to make a better producing team. Such things cannot be done even indirectly as a means of buying good will or morale—which are not "buyable."

Any permanency in the development of constructive emotional drives among workers is based upon employment justice, which must be so clearly expressed that the man on the street will be able to understand it readily.

The war has shown us that we can produce at capacity for an almost indefinite time. Industry has been able to mobilize its workers for sustained, concentrated work over a period of increasingly long hours. American patriotism, to be sure, has been one source of motivation—but there is another source, equally potent. War workers have met long hours, difficult housing conditions, food shortages, and other major obstacles to morale and have continued to carry the ball *because the purpose of industry has become the purpose of the worker; he has associated himself with the process and considers himself essential to the total effort.*

Here lies the answer to our major industrial problems. The future of our way of life depends upon the continuation of full production on a sustained basis now and after the war, and industry must take the lead in giving its people that conception and, with it, a vision of what the industrial team has as an objective.

There is no use in trying to solve the problem through a group of phrases and catchwords such as "labor management," "partnership in industry," "profit-sharing methods," and so forth. It is the fact that counts. If the war has taught us anything, it has taught us that *the forces that have brought management and labor together* have been enlightened mutual self-interest. *The cement that has held them together* has been a mutual understanding of the aims, objectives, and goals of that particular industry. The *drive that has sustained production* has been a worth-while goal which the worker could see and was interested in reaching.

The industry of the future, to be successful, will be merely a continuation along these same lines, with the emotional drive of winning the war replaced by appropriate peace-time objectives which will seem worth while in the eyes of the worker. It will not be sufficient to return to buying a man's time at so much an hour to do so much work in a mechanical, unimaginative way; in the post-war period, a man is going to want to know what the industrial team's objectives are, and why. I do not believe I am romanticizing when I say that he is increasingly going to want to know what his particular industry is trying to do, and he will be increasingly restive if he is merely told to "do that" or "do this."

There should be none of the "welfare idea" in such a policy; it should be based squarely on human drives for psychological and social, as well as economic, needs. If psychiatry has taught us anything, it is the fact that there are no lines of demarcation separating a man's various emotional desires. Industry's actual job, of course, is to see that his vocational urges are met, but that need is inexorably bound up with others, and unless the worker sees purpose and essential service in the job he is doing, agitation and unrest will follow. The progress of industry will be determined by our ability to preserve the individual while adjusting him to the central effort.

Twenty-five years ago, I said that "the man who comes along and finds a way *to complicate* industrial tasks so as to use more of the worker's capacity without reducing production will make a great contribution to both worker and management." And I repeat that statement with added emphasis to-day. Monotony, coupled with the failure to absorb a man's capacities, and the inability of the man to comprehend industry's goals are dangerous factors in any industry.

In the days of the artisans, there was a direct incentive "to get out production." The worker took pride in his own craftsmanship and struggled of his own free will to make his cabinet, or his shoes, or his table the finest that could be made. The development of the assembly-line technique has brought a sense of frustration to many workers which has been a potent factor of unrest.

In this regard, an interesting experiment is now under way

in one of the country's great industrial plants. In connection with an experimental rehabilitation program, this management is instigating trial methods in machine training. In this project, visual performance charts have been pictorially designed to show how each screw and bolt made in the assembly line fits into the final product. The new worker, viewing these charts before starting his first machine experience and referring to them as he proceeds, is thus made aware of the essential significance of each seemingly isolated procedure. Certainly this is a step in the direction of giving purpose and interest to assembly-line work, and the results of such experiments may prove highly valuable to increased production.

I refer to an orderly presentation as part of a training program that is something over and above the practice of showing the worker a complete typewriter, or a complete bomber, or any other finished product, with no real education to orient him in the production scheme.

In the type of program to which I refer, the trainee is given sufficient knowledge of the other steps and processes so that he can see opportunities for his own orderly progression to higher and higher responsibilities in the industrial team. This is done with the implication that, within practical limitations, his own abilities and his own ambitions determine his own future.

The psychological soundness of such an idea is that a man is given incentive to go ahead—he is *incentive-driven* to develop his own resources for the ultimate profit both of himself and of industry. Through such an effort as this, industry *can* make a man feel as important as he really is because industry will have the means of letting him become as important as he is capable of being.

Experiments in present-day industry extend to other psychological factors as well—for example, in the use of color on machines and work tables. In one large industrial plant, machines employ five or six different colors—such as red for the handles that start the machinery, blue for those that stop it, and so on. On work tables, designs of various colors and shapes are employed on those parts on which the precision work is done. All of these studies that industry is

carrying out seem to be a step in the right direction of understanding and utilizing the basic drives in human nature for the ultimate good of all through making the job more interesting and a bit more inspiring.

To sum up, I would stress the fact that emotional attitudes of employees toward their employment are responsible for a greater loss in dollars and cents to industry than are accidents and contagion, and that dissatisfaction and poor morale are due not so much to the employee's inability to do the job as to his inability to adjust himself to the conditions under which he must do it.

I would also repeat the statement that the function of psychiatry in industry is to seek out and correct those symptoms of maladjustment in order to save the employee in the broader interests of industry and progress; but that this neuropsychiatric service would best remain a rôle unheralded, although actually it will constitute an irreplaceable service to industry.

General principles to follow in the interest of mental health, as I have stated them, are the avoidance of paternalism, a hands-off policy regarding the employee's private and family problems, reduction of the "welfare aura," and the development in its place of a clearer understanding of the individual's need for psychological and social, as well as economic, satisfactions in his relation to his employment. We will be able to meet those needs, and at the same time increase production, when our workers become *incentive-driven* through realizing the *mutual aims* of workers and management.

Whatever means industry may use in following such principles, it *cannot* fail if in the end it succeeds *in making the purpose of industry the purpose of the worker,* so that the worker associates himself with the process and considers himself essential to the total effort. If industry can do that, then I will amend the old adage: "You can drive a horse to water—and even make him drink!"

AN INTRODUCTION TO THE PROBLEMS OF REHABILITATION*

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WE CAN no longer pay for the wastage of war in its effect upon human personality by pensions that insure economic security alone. We have another factor to deal with—a factor that to-day, and even more to-morrow, threatens to assume an ever-increasing importance. It is the factor of mental adjustment. It has to do with that part of our being which our civilization has hoped would direct and control us. We are learning to-day that the mind—or the psyche, as psychiatrists prefer to call it—may lead us into strange as well as into familiar fields and may unloose forces far more influential in determining our eventual destiny than we, as individuals or nations, had ever imagined. We are also learning that the soma may produce confusing reactions and that a sound body does not necessarily accompany a rational mind.

Now what is this force of the psyche that seeks to gain freedom and expression and that is so significant in the adjustment of people and nations and in the organization of an effective program of rehabilitation? I believe it is the pattern of individuality—that quality of uniqueness which sets one individual apart from another; that characteristic of personality which, consciously and unconsciously, we cling to as a shipwrecked sailor clings to the smallest piece of débris. If we go down, we will take it with us. We will never give it up. In the most distorted patient suffering from dementia præcox, I have seen, day after day, his effort to be *himself*, as he expresses it. Even the depredations of a disease that attacks and destroys his social structure and his social expression cannot destroy that spark of individuality.

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I have, in my experience in dealing with the mentally ill, sought some constructive point of individuality in their lives, and have often found that such a basis affords the best approach to their rehabilitation. Such points of individuality may be found in their motor skills, their unique gifts in music, art, or literature.

Educators accept this point of view, since it bases reëducation upon the vital spark of interest. In line with Dewey's dictum, they find that the therapeutic process runs more smoothly and effectively from interest to effort. The interest life of the individual provides the most practicable starting point. Our first step in organizing a program of rehabilitation should provide for a careful study of the personality pattern of the individual and the nation as a foundation stone.

There is another consideration of equal importance. One of the things that many confused people have lost in the red haze of war is the feeling of self-esteem. In the face of the Juggernaut of War, they have felt so small, so helpless, and their efforts have seemed to them so futile. They have suffered from psychic as well as physical wounds and scars. In this situation, one of the prime objectives of rehabilitation should be to increase their sense of importance, to help them to feel that their efforts are worth while, and that they themselves are necessary, for the unique contribution to life that their pattern of individuality alone can contribute.

The enhancement of personality is, in my opinion, one of the foundation stones for mental, nervous, and physical rehabilitation. One has only to talk to a forlorn schizophrenic patient who has buttoned himself up in apathy to see what happens to the personality of an individual who, through internal and external influences, has lost his sense of belonging and being worth while. In less abnormal individuals coming from this present war, I have seen many cases of those who have apparently lost the will to survive as the next step after losing a sustaining sense of self-esteem.

Educators, psychologists, psychiatrists, and other socially minded people such as you and I should be very careful to avoid putting a stamp of inferiority upon these people, which will set them apart as being conspicuously different. It is so easy to put a stigma upon the handicapped and to direct attention to their abnormalities and differences. As we

become more therapy-conscious, we will place more emphasis upon their points of similarity to the normal, in order to be of the greatest assistance in their psychological adjustment.

To sum up, I believe that we should stress the importance of appealing to the positive side of the patient undergoing rehabilitation by an emphasis upon the factors that will aid him to develop feelings and attitudes of importance and to realize that his rehabilitation is essentially a worthy undertaking.

Why do I speak of this? Simply because the rehabilitation of the citizens of the world whose lives have been impaired by this global conflict must be based upon a sound psychology, springing from the depths of their interests, wants, and racial roots. The people of every nation will decide these things from their own lives, from what Dr. William A. White used to refer to as "the life goal" of the individual. You will be able to assist in determining just what is the best approach based upon what the individual has and wants, upon what his country can afford, and upon the present level of social responsibility of your communities.

But we have another most important consideration. Will the people of the world want what they had before? Has their perspective been narrowed or widened by the red haze of war? We have reason to believe that their blood, sweat, and tears have been transmuted into a potion that will act as a powerful psychic stimulant, giving them the resolve to accept closer ties of brotherhood, leading to a more closely knit social order and a greater responsibility of one for the other. Roddy McDowell, the English boy actor, when asked his opinion of the war, replied: "It makes people more kind to one another."

There is no doubt in my mind but that systems and programs of rehabilitation to-morrow will have as a strong motivating force an increased concern of people for one another. The home land will be worthy for heroes, heroic deeds will become a part of the spiritual expression of the nation, and, one extreme creating another, emphasis upon killing will evolve into a new awakening of the social spirit in which the emphasis will be upon the saving of life and its redirection into areas of social usefulness. My third point emphasizes the importance of projecting your program of rehabili-

tation from a friendly rather than from an authoritarian basis.

What soldier does not dream of the day when he will come back to his blessed country, his home, his friends, his farm, his office, and his job? Significant as this desire undoubtedly is, I believe that it has a still deeper psychological meaning. It is partly explained by what Dr. White referred to as "the flight to the familiar," but it has even more significance than that. We know to-day that the home, with its social connotations, is a far more significant factor in mental health and adjustment than we have given it credit for being in the past. The dislocation of the home, the separation from the home and home ties caused by war, the transition from the personal freedom of the home to the regimentation of the armed forces, supplanting the protective environment of the home by the austere and demanding life of the army, are some of the factors that enter into the situation. There is also the impress of child training in the home, and the natural desire of the child to break away gradually, if at all. Coupled with this is the education of youth, with its emphasis upon spiritual values, the acceptance of the ideals of building as opposed to the ideals of war, which glorifies destruction. The child is taught that it is wrong to kill and that it is right to save life. All these ideas and ideals provide a psychic constellation which exerts a profound and telling influence upon the child, the young man, and the soldier. It is this constellation of ideas and ideals that have such a deciding effect upon his mental adjustment.

We are all familiar with the story of the English family who, to escape bombing, were ordered to break up their home life in the city of London and move to the country. The air warden soon found that, in some subtle manner, they had returned to the city after but a few months. Their explanation was that they preferred being bombed in the city to being bored in the country!

With some appreciation of the English aversion to boredom, I would hazard the opinion that there was a more significant reason. It is my belief that they would rather be bombed in their own home than be safe from bombs in some one else's home. In fact, this is brought out by Gillespie and many others who have been insistent in their belief that

the dislocation of home life is a more potent factor in the production of war neuroses than the actual combat experiences. The psychological significance of the family relation should be carefully studied for the purpose of establishing the most effective bases for rehabilitation. My fourth point lays stress upon the home in both its physical and its symbolic aspects as a fundamental consideration in programs of reconstruction.

Who are the people who will provide the human material for rehabilitation in post-war readjustment? Will they be the same as before? Will they be like those of World War I? How many will there be, and what can we do for them? These are, of course, pertinent questions.

There will be many war neurotics and psychotics, although many authorities feel that the latter group will be increased only slightly, if at all. These people think that the process of schizophrenia is deeper than the inroads of war itself. All agree that we shall find many neurotic people in all nations at war, among both the armed forces and the civilian populace, during the war, and perhaps for as long a period as twenty-five years afterward. What can we do for these people suffering from war neuroses?

We can do much for them. There is a two-sided approach to their treatment—the psychiatrist, with the modalities of medicine, treating one aspect, and the father, mother, brother, sister, and neighbor becoming helpers through another, the social aspect. Let me cite the case of Bill Tappan as an example:

> Bill had his first serious setback in Tunisia. He was diagnosed as a war neurotic and finally found himself back in this country in a mental hospital. After a period of six months, he was discharged as having received maximum hospital benefits. One might think that his troubles were over; with a pension, his economic problem was largely solved and he could go along in civil life as if nothing had happened.
>
> As a matter of fact, however, his real troubles had just begun. His wife, after seeing some examples of his overactive behavior while visiting him in the hospital, came away afraid of him, in spite of the reassuring words of the psychiatrist that this was just an episode of his illness which would be replaced by feelings of gratitude and friendliness as he improved. His mother was a discerning person, socially understanding. She enlisted the aid of her clergyman and talked at length with her son. She tried to make him feel at home. The silent dread in her heart showed, however, and Bill's homecoming was therefore uneasy. Things got better in the home, but Bill could not feel at ease in the com-

munity. His former friends seemed to avoid him, not so much because they were afraid of him, but to avoid any embarrassment on Bill's part.

A social-service worker came to the rescue. Sensing the situation, she made a rather revolutionary suggestion. Why not have a welcoming party for Bill, even though he had been home for quite a while? The mother and wife were puzzled. They didn't know whether Bill would allow it, or if he would, whether it would do more harm than good. Who ever heard of having a welcoming party for a person coming home from a mental hospital? It would seem more natural to try to forget about it all and start over again.

In spite of these objections, the party was held. Bill knew nothing about it until the guests began to arrive. A few games and songs relieved the formal atmosphere, and soon Bill began to feel that his friends really wanted him in the community. He was offered a job soon afterward and gradually adjusted himself to the community again.

I cite this case to illustrate a most important fact. It is this: Rehabilitation of the tens of thousands of men and women in this country and abroad does not end with their medical treatment. Their adjustment to society is a fundamental step in which you and I can be of great assistance.

So much for the man or woman injured in body or mind, or both, but how about the soldier who returns to civil life with no discernible wounds? Will he be the same as before, after his war experiences? Many of our psychologists and psychiatrists say no. They say he will be a different man. He will see life from a more mature point of view. He has suffered and he begins to ask himself anew just what he has been suffering to achieve. He wants to return to a home land better than the one he left, but he realizes that in many cases his home land has been destroyed. The tangible things of life are, in many cases, gone. This, however, may not be an irretrievable loss. As Walter Lippman reminds us:

"You cannot pay a soldier in dollars, in votes, in hours of pleasure, or in any other tangible thing, because these are the very things he decides to give up. It may be forever when he storms the beach at Salerno. He has not been paid at all in the only coin which is good at Salerno, unless, whether he falls or comes back, he has not suffered in vain."

We may discover that the real coin for these soldiers is psychological as well as tangible. Above all, they want to feel that they have not suffered in vain; and such a psychological content must be carefully considered in the organization of a program of rehabilitation that they will accept, and that will meet their highest therapeutic capacity.

Now that we have said something about the underlying psychology of rehabilitation, how about the techniques to be employed? Occupational therapy, recreational therapy, and psychotherapy are recognized as conventional and yet important adjuncts in the field of rehabilitation, to be used after we have made a careful study of the individual. We recognize, of course, that the individual, his wants, interests, and unique capacities, are primary, and that these branches of treatment are but adjuncts to the main body. It is necessary to determine the best type of psychotherapy to be employed. It should be understood, however, that the tools of the occupational and the recreational therapist are more than palliatives. They are instruments of psychological medicine.

The occupational-therapy aide is not necessarily concerned with making a rug as a complete and salable produce—at least she should not be. She is using these mechanical means to build mental states and attitudes. The recreational therapist is not trying primarily to develop athletes and win games, although these things may have their place. He is interested in a study of personality and the effect natural, spontaneous activities such as play may have upon it.

He seeks also spiritual and cultural values, bearing in mind the belief of the English educator, Jack, that the playground of the body may become the playground of the soul. The recreational therapist uses play to bring people into a natural and happy relationship. He looks upon a game as essentially a coöperative experience. He does not deny its competitive nature, however, and is reminded of Jack's statement that our adversary may be our best friend.

Such values are probably more apparent in the play of the mentally sick than in that of so-called normals. It is illuminating to note the many examples of the schizophrenic patient's integrating his conduct on a more stable plane while concentrating on a sport activity, and of his growing ability to play with, rather than against, people. Such social values may carry over into other relationships.

I cite these cases since by observing the extreme, we may frequently perceive processes that are equally present in so-called normals. It is my belief that these psychological processes are vitally important in the organization and administration of the most effective type of rehabilitation.

In this connection, it is my firm conviction that society at large is about to enter upon a more humane as well as a more realistic understanding of the mentally handicapped. No one can predict how many we will get from this global conflict, which, in addition to the physical injury of shells and bombs, has presented us with the numerous problems of malnutrition and the many psychological problems arising from the dislocations of the home front. Society has overestimated the element of danger in the treatment of the mentally ill. Society has also made the big mistake of believing that peculiarity of conduct means dangerous behavior. There are thousands of mild mental cases to-day who, under the economic acceleration of war, have been given a chance to reënter industry and are making good. There are many other thousands who could go back on the job if the community knew more about mental illness and were able and willing to assume its responsibility in their adjustment.

It is a commonplace that a mentally sick patient on the job is worth ten incarcerated in a mental hospital. We must be willing to take a chance on the ten still in the hospital. After all, it is a very serious responsibility to deprive any one of his freedom unless we can establish something more in the way of an antisocial threat than peculiarity of conduct. The fact is that many peculiarities may be mitigated and controlled by understanding in the home and community. If I had the time, I could cite scores of cases that have come under my observation over a period of many years in which mentally sick patients who were considered incurable have been able to make a satisfactory adjustment to their homes and to industry, once they had been encouraged and helped by an understanding society.

How are we going to assist the returning men and women suffering from war neuroses? In the first place, we must have an elementary understanding, at least, of this particular condition.

What is a war neurosis? I know of no other word that has been used more frequently in discussing the effects of total war. In the first place, it is important to remember that there is no such thing as shell shock, a term used loosely to describe any and every thing that might happen to the

mind—from the bursting of a shell to the disappointment of the soldier who has not heard from his best girl.

Moreover, a war neurosis is a mental condition that, as distinguished from a psychosis, is much more likely to respond to treatment; also, it is rather on the psychological than on the physical level. It has more to do with our relationship to people than with the physical condition of our bodies; it is a social disorder of the individual. It is this social nature of the illness that opens the ways by which you and I can assist in the more general problems of rehabilitation.

A neurosis may happen to any one. Myerson states that neuroses are like Caesar's greatness—some are born with neuroses, some achieve neuroses, and some have neuroses thrust upon them. It is the belief of many psychiatrists that every one has his breaking point, from which he will retreat into a neurosis.

How does a war neurosis arise? While acknowledging the contributions of heredity and environment, one may say that it arises from a mental conflict—a deep conflict between one's fierce, instinctive love for one's country and one's love for one's own life; a conflict between the desire to live and the desire to give up one's life; a conflict between the ideals of patriotism and the inherent ideals of peace.

I talked to a young neurotic soldier just the other day as he came over with his ward for recreation. He had just come back from Africa.

"It was a question of me or my country," he explained. "I could not let my country down. If I can only be a man!" he continued.

Let us see just what happened in the life of this young soldier who had gone forth to battle. He had reached his breaking point, and this is surely no disgrace. As I have said, it is the opinion of many psychiatrists that we all have a limit beyond which we cannot go without sacrifice of our mental balance. By a subtle mechanism of human nature, a mechanism that I feel may be providential in many cases, he was able to escape the remorse, the effects, and the challenge of such a great decision. He simply escaped into a neurosis. He did not do this purposely—he was at heart a brave

person. As in the case of Bill Tappan, the unconscious came to the fore and simply wrapped a blanket of forgetfulness around the whole experience and hid it away so that he would not have to worry about it.

This was not all, however. The unconscious did something far more spectacular. It brought out some peculiar, instinctive movements that he could not control. While he could not control these grotesque body movements, he could perceive them and they worried him. One arm, which he explained had held the gun, was paralyzed by hysteria.

We learned from his case history that he had played volley ball in the army and in high school. We led him on to the volley-ball court and put a volley ball in his hand. He fondled the ball in a sort of embarrassed fashion, began to hit it on the floor and then hit it over the net, saying all the while: "If I could only be a man!"

Shortly afterwards, he was playing an exceptionally alert and intelligent game in one of the Perry Point leagues. Here we have a simple case of rehabilitation, of reëducation, of the reawakening of early play patterns as the basis of a gradual reorientation into higher forms of activity. This war will bring us many thousands of such cases, in which individuals such as you and I will be able to give most valuable psychotherapeutic assistance.

These neurotics are highly suggestible. Their physical and mental tolerance is low and they are prey to all kinds of tormenting worries. They need to be reassured, to gain insight and understanding. I make it a point to tell them that, while they are in a highly nervous and disorganized state and might naturally feel that they have about reached the end, their symptoms are more acute than the disease itself. They will, in most cases, get well with proper care, treatment, and understanding.

It is well to repeat that the rehabilitation of the individual suffering from war neurosis will be one of the great and challenging problems requiring your aid for its solution. In modern war there is no actual war front. As we well know, women, children, as well as soldiers, are affected. Not only the regimentation of actual fighting, but the necessary dislocation of life and the regimentation in war industries

produce conditions that may bring about various types of neurotic reaction.

But we are told to-day that the largest proportion of the individuals who become subject to these mental conditions are predisposed—that by careful psychiatric examination at induction centers we can screen them out and settle our problem at this stage. Let us get the facts on this.

Twenty-nine million men have registered to date for selective service. Out of ten million examined for service, over two million, eight hundred thousand have been classified as 4-F (unfit for any form of military duty). The general rate of rejection at this moment is 39 per cent and it is on the upward trend. Between July, 1941, and January, 1943, the discharges for neuropsychiatric disability totaled more than one hundred thousand. Seventy per cent were screened out and thirty thousand, or 30 per cent, were discharged for mental or nervous disorders after some time in the service.

More than twenty have been kept out for every one who has broken down in the service. Age is a most important factor. At forty-five years, only four out of twenty can qualify; at eighteen years, fifteen out of twenty qualify. As we know, educational deficiency decreases with age; in psychosis, drug addiction, and inebriety, the rejection rate at forty years is double that at twenty years of age. Psychoses and psychoneuroses are four times as prevalent among whites as among Negroes, as causes for rejection.

In conclusion, what are some of the fundamental considerations you and I should take into account in the organization and administration of a practical program of rehabilitation? I would like to suggest the following points:

1. Rehabilitation in the past limited its outlook and responsibility to the idea of monetary payment for injury to the body. To-day a progressive idealism has raised the concept of rehabilitation to the retraining of the individual for the purpose of restoring physical function leading to employability. Recently, for the first time in our history, legislation has provided for the rehabilitation of the mentally handicapped. This, in my opinion, is going to be a big problem here and in other countries.

2. We have reason to believe that in the future the work

project and the work environment will be more personalized. More stress will be placed upon workers as people, upon their natural abilities and interests. Healthful adjustment to life as well as high production of goods may provide practicable objectives.

3. Society at large will assume its responsibility to assist in the employment of the eight thousand individuals who are being discharged daily, many of them unable, because of personality inadequacies or deficits, to fit into a work regimen based upon considerations other than their personal abilities and interests.

4. Methods and programs of rehabilitation will aim to restore human dignity in productive capacity. We are realizing to-day that the meaning of work to the worker is as significant as production—or even more significant—in a long-range study of employment.

5. Modern society will, through education, discard the fallacy that a difference in any respect means a decrease in value. Psychiatry and the other medical and psychological science, it is hoped, will be more careful to avoid putting a stamp upon the handicapped individual. We must assist the worker to avoid succumbing to the fatalistic psychology that being different because of some handicap makes him unwanted. We must remove all such implications of stigma.

6. I believe you will agree with me that education is getting away from the academic detachment of the past into closer human relationships. The English people have reminded us that if war serves any constructive purpose, it helps people to get closer to one another. The school of human relationships may be the school of the greatest promise for the future organization of the most effective system of rehabilitation.

7. I am, I hope, not getting too far away from base when I suggest that you and I might well begin to examine some of the newer concepts of work from the standpoint of its emotional nature. The psychoanalytic point of view of work and worker-employee relationships, as has been recently developed by Karl Menninger in his latest book, *Love Against Hate,* is, in my opinion, far more than theoretical speculation.

8. A committee of the British Medical Association, after a three-year study of mental health and rehabilitation, recently submitted a report that emphasizes the importance of public

education of mothers, nurses, and teachers in the management of young children, in teaching the young child how to live and how to handle his instinctive urges, in recognizing early stages of mental illness for successful rehabilitation; and the importance also of better education of the practitioner, so that he may protect and guide his patients from the earliest years. The causes of mental illness were grouped under the headings (1) Environmental and Constitutional Factors; (2) Environmental Emotional Factors in Early Life; and (3) Similar Factors at the Time of Illness. From this emphasis upon the emotional content of mental illness, one can envisage the broad and deep field in which you and I, as members of the community, may be of assistance.

I am sure that you will find this problem looming large in your efforts to be of service in the various countries from which you come. No one can estimate the number of potential cases of war neurosis. By starting with the children, many can be prevented from developing, and others can be more successfully treated.

9. Recent statistics point to the conclusion that most forms of illness for which a physical basis can be found are likely to decrease. On the other hand, many types that have no discernible physical basis and that are highly colored by social implications are on the increase. To-morrow we shall have to pay more attention to the mind and its complex and puzzling reactions. While we may be sure that man will use the greatest ingenuity and resourcefulness to restore his mechanical usefulness, impaired by war, the mind will still refuse to be governed by such mechanical means. The mind needs far more than mere physical aids. The history of our civilization attests to this fact.

One reason why we cannot afford to be dogmatic and to say the final word on the subject of rehabilitation is that the subject of this process, man himself, is a growing organism; he changes from day to day and undergoes more rapid change under the stimulus of war. Ideas and ideals also change under the impetus of their own force, so that what we accept to-day as law may become a theory to-morrow, and possibly be discredited later on; while what we may look upon as a fatherless postulate to-day may become a controlling factor to-morrow. It is in this evolution of people and ideas and

ideals that we may finally find the most satisfactory concept of rehabilitation and be able to discover the area and the ways in which you and I can make our most distinctive and effective contributions.

I know of no better expression of the future possibilities than the words of Will Durant.[1] I quote:

> "Psychology stands to-day where physics stood when Francis Bacon wrote his *Advancement of Learning* three hundred years ago. With an audacity that startled even the brave Renaissance; Bacon laid down a program for the sciences, pointed to the vital problems that craved solution, and predicted, on page after page, the conquests that would come with the new knowledge. To-day these physical triumphs are real, universal, and profound, far beyond even Bacon's royal imagining; and everywhere physics and chemistry, mathematics and mechanics, have remade the face of the earth nearer to the will of man. Only man himself, his will and his character, seem to have remained unchanged.
>
> "Synthesis is always more difficult than analysis; psychology has not yet put together the human nature which it has taken apart; and it is still easier to describe man than to say what he should be and how he may be changed. We have touched one aspect of a great subject which in our century will draw many initiative minds. We have the knowledge, now we seek the art, to remake ourselves as we have remade continents and seas. But knowledge is power, and every science becomes an art at last, bringing forth fruits to enlarge the empire of man. Before our children pass away, man will be building minds and hearts as to-day they build ships and planes. Human impulses, which have remained becalmed and almost changeless while all the world without has been transformed, will be consciously reshaped to the subtle and accelerated life which restless invention makes. Already the mental capacity of man has been increased and multiplied, so that the highest modern mind seems to belong to another species than the slow reactions of the peasant. Some day our brains will catch up with our instruments, our wisdom with our knowledge, our purposes with our powers. Then at last we shall behave like human beings."

Do you agree with Will Durant? Well, at least it's worth thinking about.

[1] From *The Mansions of Philosophy*, by Will Durant. Garden City, New York: Garden City Publishing Company, 1941.

MANIFESTATIONS OF PSYCHO-NEUROSIS IN NEGROES

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ONE of the most significant disclosures resulting from our recent experiences in organizing an army has been the extent of the problem of the "psychoneurotics." This word has become a familiar term, if not a very clear conception to most laymen, and physicians, social workers, and others with a professional interest in the subject are rightly trying to allay the public's apprehensions and distrust of individuals so classified by interpreting the real meaning of "psychoneurotic" as "maladjusted" rather than insane.

An interesting, but unfortunate aspect of this problem is the almost complete lack of recognition of neurotic behavior in the Negro race, if we are to judge by the dearth of written material on this subject. We seem curiously blind to the fact that family problems, marital difficulties, the stresses of urban life, and war-time adjustments affect all persons in a given setting, regardless of skin color. These factors probably affect the Negro even more keenly than they do the white person; he has less security, more to lose, greater fears. His wages are most quickly reduced; he is the first employee to be laid off; he is the one who must crowd into a small house and then double up and share again because he cannot expand or buy space even with money. His problems are intensified; he grows more restless as he awakens to opportunities he now has, but may lose.

The new generation, as it strives to make a different and better place for itself in the new society, becomes subject to the pressures and conflicts generated by society and by the changing individual himself. He is trying to break away from the old paternalistic set-up his parents knew on the farm or in household service "on the lot," and he wants to follow the urban pattern of comparative personal freedom.

We allow ourselves to believe that the Negro still lives in a movie-land of banjo-playing, cake-walking, and magnolias, care-free and light-hearted. But no one who has worked with

Negro families can forget the grim struggle to meet the rent, the bitter wringing out of a few pennies for burial insurance, the borrowing of three lumps of coal on a biting cold day from a more fortunate neighbor, or the sense of utter frustration at the absolute inelasticity of money. We overlook the obvious fact that Negroes are raised in the same civilization as the white members of a community, read the same advertisements, stare into the same shop windows, and have the same ambitions for themselves and their children for education, economic security, and happiness in general.

The experiences reported in this paper grew out of my work as a medical social worker at Grady Hospital, the city hospital of Atlanta, Georgia. My interest in presenting this brief sketch of them is to point up the problem that exists in the hope of perhaps stimulating others to attack it.

At Grady Hospital, because of lack of facilities, no treatment for psychoneurotic patients is attempted except in a few instances where the help of the social worker appears to be adequate, or when reference to a family welfare society for help in a concrete, very specific problem will enable a patient to bring out and handle emotional factors.

My rôle in the latter situation is that of interpreting to the patient the difference between how a doctor could help and how the social-work agency might help. It is always extremely difficult for the patient to relinquish the idea that he is ill and to accept the help of a nonmedical person, since that, of course, deprives him of his illness and his escape.

My interest is not in the psychotic patient who must be institutionalized, but in the individual who lives at home and remains a member of the community, but who fails to adjust in a fashion satisfactory either to himself or to society.

One of the great handicaps in working with the Southern Negro is his outer subservience, which often masks inner rebellion, and his ready agreement with the white person to whom he is talking. The Negro acts as he is expected to act and not as he really feels, since he dare not express resentment or opposition. No real rapport can be established, as the Negro is not his real self nor can he share his innermost self in his relationship with a white person. On this basis, of course, a therapeutic relationship is impossible.

Another difficulty—and a very frustrating one—is the

Negro's inarticulateness and inability to introspect, to analyze his ideas and emotions. He simply cannot explain or begin to take hold of his difficulty except to say that he has "a hurtin' " or "feels puny." With more education and consequently a larger vocabulary, with more experience in expressing himself, the Negro will gradually reach the point where he can make a better use of psychotherapeutic help.

I found that our patients used the same patterns to express their neuroses as do white patients: severe headache, eye difficulties, asthenia, gastrointestinal ailments, vomiting and anorexia, generalized fatigue, "nervousness," apathy, and "drawing spells." This last manifestation is so common that probably all the Negroes of Atlanta are familiar with the remedy known as "the blue bottle." Hardly a day passes but a patient is carried into the emergency clinic in an apparently semiconscious state, with head lolling and arms and legs making jerky, convulsive movements. The seizure is brought to a rapid end by one strong whiff from the blue bottle, which contains ammonia. Investigation in these cases invariably reveals an unstable individual with an unsatisfactory home life. We see many patients who have an hysterical loss of speech or of motor ability.

The problems referred to us follow the standard patterns of rebellious adolescents from overstrict homes with domineering parents of rigid middle-class morals and standards, or from loosely woven households where children were "just left" as babies and raised, and where a succession of vaguely connected people drifted in and out, staying a few weeks or a few months. A nervous, unstable child, growing up in an insecure world, without a real sense of belonging, watching this up-and-down, in-and-out type of existence, may very well suffer an aggravation of his already developed fears in his struggle with the problem of growing up and daring to be on his own. The case of Jimmie, which follows, is an illustration of this. The treatment here was handled by a social worker trained in certain aspects of such cases as his.

> Jimmie was a fifteen-year-old boy who was brought by his "aunt" to the clinic with a complaint of generalized fatigue and severe headaches. He seized upon and claimed for himself every symptom the doctor brought up. Physical examination, X-rays, and laboratory studies were essentially negative, and Jimmie was referred to social service for further investigation and treatment if the worker felt able to handle the situation.

We found Jimmie to be a small, dark, attractive-looking boy, with a soft voice and rather effeminate manners. His eyes were bright and with a little encouragement his words tumbled out quickly, as he talked of his home life and his problems.

He had lived with his eighty-four-year-old grandmother since the age of two, when his mother had left him and disappeared. The only other member of the household was his "Aunt" Marie, who really was no relation, but who had been similarly left with the grandmother and raised by her. Jimmie's father was employed in Detroit and contributed adequately to the boy's support, so that the family lived in a nicely furnished housing-project apartment, and Jimmie dressed dashingly in the sweaters, tweeds, and sloppy jackets affected by high-school boys.

In our talks with Jimmie and the other members of the household, we were impressed by the warm, close relationship that existed between them and the protectiveness felt by each for the others.

In spite of this, Jimmie felt extremely insecure, concerned over his mother's rejection of him and his father's remoteness. Moreover, his grandmother reminded him continually that she would probably soon die and that he must then do thus and so. Jimmie explained that she was trying to help him face the future, but her exhortations always left him feeling very much alone.

His school work was unusually good, with one exception, and he led a normal social life, associating with a group of boys and girls of his own age and interests. He was active in church work, sang in the choir, and taught in Sunday school. One of his most pressing problems was love; he was somewhat concerned over being in love with three girls at once, but thoroughly enjoyed making each one think she was "the one and only." However, he did not take this too seriously.

The exception to his good school work was algebra, and he focused all of his insecurity on that subject, so that when he rose to recite, the problem that had seemed lucid the evening before became a meaningless jumble and he could not begin to solve it. He was then seized by a severe headache, a general feeling of being ill, and had to sit down.

Jimmie's problem seems to us typically one that sets up patterns leading to neurotic behavior unless handled in time. When first seen, he had asked the social worker to secure a note from the doctor for his teacher asking that he be excused from the algebra class on the basis of his health. After a series of interviews, Jimmie was not only able to do his algebra problems, but had become the teacher's pet. His headaches had almost disappeared and he had made progress in working out his relationship to his father and his grandmother.

Marital and sexual problems are similar to those that face white persons. All Negroes are not sexually promiscuous, sensual, and immoral, and many unhappy situations arise because a man and his wife are not able to make a satisfactory sexual adjustment. A familiar complaint of women patients is "nervousness," which on further inquiry is found to be dissatisfaction because the husband is either impotent or not willing to satisfy his wife, who may be quite demanding.

Other women try to find in clinic attendance an excuse for avoiding sexual intercourse, which they dislike or fear because of the possibility of becoming pregnant. Often prejudice against contraceptives is so deep-seated that a woman does not make use of our contraceptive clinic in spite of the doctor's recommendations nor can any amount of reasoning change her feeling that contraception is wrong. Thus anxiety is increased over what it might be if prejudice did not exist.

Many of our patients are the familiar type who flit from doctor to doctor seeking some magic, nonexistent help. Since our patients are poor, they can afford only the city hospital, but this answers the same purpose, with its many clinics and busy doctors who have time to treat not the patient, but only those sores or pains which can be ascertained by examining, testing, or X-raying. The huge amounts of liquid, powdered, or pilled medicine consumed by neurotic patients who can benefit only by psychiatric help is appalling and quite depressing. Frequently, when a patient is finally dismissed from the clinic as not organically ill, he often turns up several months later with a new set of complaints and begins his rounds from the medical clinic to the genito-urinary, to eye, to surgery, to proctology, and back to medicine.

A problem already becoming serious is that of the returned Negro veteran, who has the same problems as the white veteran, but with the added burdens that his race has always faced. He finds it difficult to return to his old subservient place. He has some pride in the fact that he was a soldier and feels entitled to some swagger, believes that he sacrificed something in going into the army and deserves some reward in the way of more respect and an opportunity to earn a better living. His very discharge from the army is a problem in itself and hard for him to explain unless he has an obvious physical defect such as a broken arm, leg, or neck. He cannot show people his ulcer, he cannot demonstrate his epilepsy or explain his psychoneurosis. The fact that he was accepted and then discharged somehow makes him a less fit man in the eyes of his neighbors and future employers than if he had never been inducted.

As we try to extend the benefits of mental hygiene and psychiatric help to an ever-increasing group, we must not forget or neglect the Negro.

SOMNAMBULISM IN THE ARMED FORCES*

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SOMNAMBULISM is a neurotic reaction evidenced by a dissociation of personality. Sleepwalking represents a flight to security and protection from a threatening environment; usually it is a recapitulation of the soldier's earlier attitudes in infancy and childhood. We wish to present a series of twenty-two successive cases involving soldiers with a history of somnambulism.

Although it is generally known that somnambulism is frequently encountered among children, we have also discovered that it is of much more common occurrence among adults than is generally believed. Actually, eighteen of our group of twenty-two men had a history of somnambulism prior to their army induction. It is important to bear in mind that in half of these cases the original presenting symptoms that brought the man to our attention were somatic complaints and not somnambulism. There is a conscious effort on the part of the patients, and a willful determination on the part of their families, to suppress a history of somnambulism, because, like mental disease, it represents a blemish on the family escutcheon.

Somnambulism is a real problem in the military service. It represents a direct threat to the sleepwalking soldier, for during his nocturnal perambulations, he may injure himself, or he may be shot because of failure to halt at the guard's command. In addition, it also raises a morale problem for the sleepwalker's barracks mates, since in his nighttime

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activities the somnambulist not only disturbs the sleep of his fellow soldiers, but also arouses an uneasy feeling that they have a disturbing and "queer" comrade in their midst.

Most of our twenty-two somnambulists had presenting symptoms of a neurotic character. One soldier came because of a tremendous anxiety about going blind; it was associated with a constant feeling of falling into an abyss. Another soldier came because a feeling of a lump in the throat; another because of claustrophobia; still another because of tremulousness and headaches. Several of the men came because of headaches and dizzy spells. An interesting finding was that when the sleepwalking episodes diminished, the somatic complaints increased. There seemed to be an inverse relationship between somnambulism and somatic complaints, which may be interpreted as manifestations of anxiety stemming from repression, reducing the necessity for its release through somnambulism.

The duration of sleepwalking in our patients varied from two weeks to twenty-four years. Five had been sleepwalking for more than fifteen years. Less than a fifth had begun their sleepwalking episodes in the army. The precipitating feature in the somnambulistic episodes was usually some traumatic experience which had occurred earlier that day or which the man was anticipating in the very near future. On a number of occasions, somnambulism began with a physically traumatic experience, the very life of the soldier being threatened. This is illustrated by the following cases. One soldier developed pneumonia and was nursed by both parents. In turn, they contracted the disease, from which they both died. The shock resulting from the death of both parents, together with the soldier's subsequent enfeeblement, was the traumatic factor. In another case the soldier had pneumonia followed by scarlet fever, and upon recovery had a tonsillectomy. Apparently the tonsillectomy was associated with castration anxiety.

In other instances, we found that the first sleepwalking episode followed some psychogenic trauma. In one case in which somnambulism began in the army, it occurred immediately after the soldier had said good-bye to an intimate friend who was being sent overseas with another unit. In this case the separation recapitulated similar experiences in

the soldier's childhood, when the father and the paternal grandfather had said good-bye by way of suicide. In another case, sleepwalking followed the marriage of the soldier's favorite and dearly beloved sister to his closest friend. In a third case somnambulism began after the marriage of the soldier's best friend. In another situation sleepwalking began when the soldier failed in his senior year in high school, returned home after being notified of his failure, and then was rejected by his idolized father, who was a very successful attorney.

The frequency of sleepwalking varied from irregular and occasional periods to nightly episodes. It is of considerable interest to note that after treatment with sodium amytal, followed by psychotherapy, the frequency of sleepwalking was markedly reduced. In one case the reduction was from an average of five times a week to only once during a three-months period. In another case, where the cycle was every night for one week every other week, it was reduced to five episodes in three months. In this particular case, two of the sleepwalking episodes occurred during the week of the soldier's furlough. He visited his wife who was about to be delivered of his baby! This upset him no end.

By the use of sodium amytal intravenously in a number of cases, we were able to elicit repressed material of great importance diagnostically which otherwise might not have been obtained. In somnambulism there is a struggle between the super-ego and the id. The conflict is between the patriotic, social-ideal self, which is gallant and valiant and is prepared to make all the necessary sacrifices for the preservation of our country, and the other self represented by that aspect of the individual's personality which refuses to make any sacrifices, desires to avoid hardships, and is unwilling to make any contribution to the common good if it threatens his comfort or safety. This dissociation and intra-psychic conflict of sleepwalking was clearly manifested by one patient who stated under the influence of sodium amytal:

"I want to do my part, but this other man inside of me won't let me. I want to help out in this war, but there's this other fellow who has more influence over me than anybody. He is constantly in my dreams. He keeps telling me: 'You could do much better on the outside. You could be a

great help in defense work.' But I keep telling him I want to help out—I have to help out—but he replies: 'My boy, you are lucky you are alive. I will help you out. I will get you out of this; if you stay in, you may never come back. Be sensible!'

"He makes me get up and walk around. He won't tell me where I am going. I wake up and I'm fighting him off, but he won't let me fight him off. He tells me I am just an ordinary person—that I am young. I still have a right to live in a free country. I tell him I have just as much freedom as anybody else. I tell him I want to do my part no matter what the sacrifice is. I should die for my country. My father fought, so I should fight for it, too."

While still under the influence of sodium amytal, he was asked who this man inside of him was. The patient replied:

"This fellow inside of me doesn't have any name. He thinks of all the sunny things. I was taking this basic training; then this fellow comes along at night, and he says, 'Get up! Get up! Get up!' I get up and walk around. I don't know where I'm going. I don't want to go there. My father used to say, 'My boy, we are living in a great country.' He wants to feel that one of his sons is doing his part in this war. But that fellow makes me think I don't have to do it. He makes me toss about in my bed at night. He says, 'Listen here, boy. You are a nice fellow. You could do so much better somewhere else.'

"I thought that maybe I could make a good soldier, but this fellow keeps bothering me. Sometimes he is so nice. He says, 'I will let you rest a couple of days at a time or a week, or according to how you feel.' This man keeps saying to me, 'This war is a great thing—but you could be doing so much for the government back there—helping to build planes, tanks, airplanes, ships.' He is very kind, this man, but when he tries to keep me from doing what I want to do, it's so bitter. He says, 'You want to come back to build planes or something like that. You want to help out in other ways.'"

In four of the first ten cases that were studied intensively, one or more members of the immediate family and some blood relatives were somnambulists. In four other families, there were members who were neurotically ill. In three of

the cases, we obtained a history of suicides or psychoses in the immediate family. A remarkable thing in these histories was the finding that, unlike the ordinary run-of-the-mill neurotic, these somnambulists did not come from broken homes, and in only one instance had the parents died prior to the soldier's reaching his adulthood.

Most of the fathers in our series of cases had some disease, such as a respiratory condition, cardiac disease, hypertension, or a "painful back." These men had been exposed early, therefore, to illness of their ego-ideal, which inculcated within them the need for securing even greater protection for themselves and created an ever-constant dread of being separated from the loved parent.

The fathers in the entire group were feared, respected, and idolized. The soldiers painted a consistently rosy picture of their fathers. Nine of the twenty-two men were so emotionally attached to their fathers that they had selected the same vocations and expressed considerable satisfaction at having worked with their fathers. In contrast to the fathers, seventeen of the mothers were placed in an inferior status and were described as "nervous"; eleven were characterized as domineering mothers, who did the family whipping. One soldier spoke of his mother as "the keeper of the cat-o'-nine-tails."

In their relationships with their siblings, the somnambulists evidenced a definite trend toward infantilism. They solicited the attention and libido of the older brothers. Half of the entire group of twenty-two were the youngest of very large families. When they were not the youngest, their relationship with the youngest was one of rivalry. These somnambulists were insatiable in their need for affection, but because of their large families, the supply of affection and attention was limited and the demand remained unsatisfied. In discussing their childhood, these soldiers frequently pointed out with much apparent pleasure how often they had received gifts from the oldest brothers or sisters. The oldest brother generally stood in the father rôle to the somnambulist.

One of the most fascinating and important discoveries in this investigation was the inadequate heterosexual adjustment. Nine of the sleepwalkers were single. These men commonly showed either no interest or a superficial or merely

lukewarm interest in women. This significant finding was largely verified through home contacts by American Red Cross field investigators. One soldier expressed his interest in women in this way: "I went out a few times with girls, but I guess it was because of the good home cooking." Another soldier stated his attitude thus: "To my mind, getting married is ridiculous. I have no desires, and it would interfere with my grand scheme for myself. Personal independence is my goal." A third soldier commented, "The guys in the barracks can't figure out why I don't bother with them. Why should I have sex experience? I'm not interested in women."

Of the thirteen married men in the series, five were divorced, and had followed their divorces with early remarriages. One soldier, twenty-nine years of age, had married three times. These rapid remarriages were probably indications of the soldiers' deep feelings of insecurity and emotional dependence. It is noteworthy that in no case in which the soldiers had experienced divorces had their own parents been divorced or separated. Sexually, the somnambulists were not very successful, and they had repeated their marriages as an attempt to muddle through their sexual difficulties. These divorced men all projected their previous difficulties upon their former wives and held them responsible for their own sexual inadequacies.

Where the marriage had persisted or had been followed by remarriage, the heterosexual drive seemed weak indeed. One soldier, recently remarried about two months before, feared meeting his wife because of his impotence, and stated, "I have no desire. How can I face her? She will accuse me of being unfaithful. That's the only conclusion any woman can draw!"

In another case, the wife volunteered to the Red Cross interviewer that the husband often remained months without approaching her sexually. In the same case the first child was to be born eighteen years after marriage! In this particular case, the soldier expressed great concern about his wife and her condition, but he did not care to make any effort to obtain a furlough to be present at his wife's delivery. He did, however, request a furlough to see a sister who had a chronic illness.

In another case, the wife gave up her position, closed her household, and started to join the soldier, but the man refused to allow her to come to visit him. While under the influence of sodium amytal, another somnambulist who is married stated, with a great deal of feeling, that "sex is such a disgusting thing," and disparaged the sexual relationship in marriage. This soldier's wife had complained that at night he habitually neglected her and spent all of his evenings at home working upon his hobby—some mechanical device—using the latter as a pretext for not being attentive to her.

A fourth somnambulist, under sodium amytal, admitted that he had been married three times, although in a previous interview he had neglected to mention this fact. He excused himself by stating that he had forgotten about the other two wives. During his first two marriages, both wife number one and wife number two had had an illegitimate child. The first wife had had a child by a very close friend of his, and upon his discovery of his wife's relationship with this man, the soldier had assaulted him. The second wife had had a child by the soldier's eldest brother. When questioned as to what course he took about this matter, the soldier replied, "Why, I forgave him, because it is wrong to beat up a brother." Shortly after the third marriage, this soldier had been inducted.

Another soldier manifested great unconscious hostility toward his wife, as indicated by the following dream and behavior. He dreamed that he was plowing his field with a stubborn, obstinate mule. He said, "That mule made me so damn mad I socked it, and when I awoke, I found that I had socked my wife in the face and punctured her eardrum."

It was an interesting fact that during the administration of sodium amytal, when these men were questioned about their sexual adjustment to their wives, they showed their great resistance by squirming in bed, turning their backs upon the examiner, or commenting upon the painfulness of this line of questioning.

A clue to the heterosexual difficulties experienced by these men may be found in the case of a somnambulist who had episodes beginning at the age of four and continuing to twelve. When sleepwalking ceased, it was followed by the practice of overt homosexuality, which has continued to date.

A study of the family relationships and domestic situations of these men revealed some interesting and startling facts. In going through the family backgrounds of the twenty-two cases, we were greatly surprised to find that most of the men came from large families, the average number of children in the whole series of cases being 6.5, which is more than double the average number of youngsters in the American family. Coming as they did from large families, one would naturally expect that, emotionally and biologically, they would wish to produce large families in their turn, but we were amazed to find that the average number of children of the thirteen married men in this group was only 0.45, or less than one-half child for each married couple. This immediately stirs up conjecture. Our feeling is that the great emotional immaturity of these soldiers, together with the fear of recapitulating their early sibling rivalries, has produced in these men both an undercurrent of insecurity and a desire to avoid any real family responsibilities. These men have little or no wish for children, for then they themselves would be displaced.

Surprisingly enough, in the matter of intelligence, these men represent a higher level than the average population. In four cases, the army general-classification-test scores were unobtainable, but three of these four men were high-school graduates and the fourth had completed grammar school. Of the other eighteen cases, the test scores showed that five classified in Group II (superior), another five in Group III (average adult), and eight in Group IV (normal). As to formal education, two men had had more than two years of college; four were high-school graduates; and the median educational attainment was elementary-school graduation.

The ages of the men ran from eighteen to thirty-seven, with a median age of twenty-six, which compares favorably with the median age of the entire army.

It is a popular superstition, and it has been stated in the literature, that sleepwalkers do not injure themselves. This is incorrect. One of our somnambulists had fallen down a flight of stairs; another had burned himself against a hot stove; a third had fallen over some bunks; another had stumbled over some foot lockers and injured both lower

extremities; another had run through a screen door, injuring himself.

The activities of these men during their sleepwalking showed considerable variety. A large number of them had a compulsion to go to the windows, either to look out or to attempt to climb out. Many of them walked to the latrine in their sleep. While it may be true that going to the latrine at night is a common activity of the normal man, yet these men apparently had other motives and reasons for doing so besides seeking relief from the distress of a full bladder. If this was a physiological activity, would they not have done some sleepwalking every night? None of them had complaints involving the genito-urinary tract; none of them were bothered by enuresis or nocturia. An important factor is the association with penile activity. Actually, many of these soldiers found themselves in the latrine and awoke without urinating. Can it be that these men are drawn to the latrine because it is a place where men congregate and display themselves?

In addition to the above activities, there were other curious episodes in which these men indulged. In one instance, a soldier had walked many miles cross-country to the home of a paternal uncle who had replaced the deceased father in the soldier's affections; another soldier walked fourteen blocks; in other cases these men had walked over difficult terrain—in some instances even over streams on narrow logs—to get to their destinations. One soldier, when at home, frequently dreamed during sleepwalking of asking his father for a gun, and the father usually acquiesced by saying, "O.K. I'll give it to you," which would satisfy the somnambulist, and he would return to bed. Actually, the father would be walking along protecting the man from harm.

The night personalities of these men were in marked contrast with their gentle dispositions during the day. During their sleepwalking they were argumentative and hostile, which probably was indicative of their basic character, which was repressed from consciousness. One man started a fight with a guard, knocked him down, and thereby risked being shot. Another soldier went to the clothing of his best friend, took out his friend's wallet, and hid it in his own foot locker. When he awoke and found it there, he was horrified.

As previously reported, one man frequently beat his wife during these episodes and punctured her eardrum. Another man, on a number of occasions, would grab up his wife and start out of the house at a run, because he feared that trees or large objects were about to fall on her. Another would sit near his wife's bed with a shotgun, his finger on the trigger, muttering something about a Negro. This same soldier in civilian life was a Sunday-school superintendent and seemed greatly embarrassed and disturbed when his barracks mates told him that he did a great deal of cursing during the night. This seemed to bother him more than his sleepwalking. One man, upon occasions, would urinate upon his wife in bed and upon objects belonging to her. One soldier, following some aggression toward his commanding officer earlier that day, urinated in his neighboring corporal's butt can.

One of the intriguing features of the somnambulistic situation is the dream life of these men. One soldier stated, "I dreamed I jumped on my brother, and I was riding him like a reindeer while I was beating hell out of him." Another said, "Very frequently I was about to be killed when my father would appear on the scene and come to my rescue."

During the sleepwalking episodes, many of these men had severe anxiety emotions, or shall we call them "nightmares"? A frequent theme of most of these dreams was the ever-present tremendous snake. One soldier described a recurring dream in which the snake was twenty-five feet long and about four feet in diameter. It always attempted to squeeze him to death. In other cases the dream content centered around the dreamer's being chased by a Negro with a knife or a dagger. Other dreamers found themselves pursued by hydrophobic dogs, movie monsters like Frankenstein's, armed Nazis, Japs, head-hunters, and so on. At other times they were chased by animals, such as a panther, a horse, a bear, or a steer. These dreams were usually associated with the sleepwalking. A few of the dreams were concerned with drowning in a muddy stream. One very intelligent sleepwalker expressed his feelings during his somnambulistic episodes as follows, "It's something that is after you, but you don't know what. It's something you want to get away from."

CONCLUSIONS

From our study of these twenty-two cases of somnambulism —which, after a review of the literature both in English and in foreign languages, we believe to be the largest number of cases so far studied—we have formulated the following conclusions:

1. The personality structure of the somnambulist is that of the overprotected, babied adult; frequently he is either the youngest child in a large family or one who desires to be considered as the family infant. He has generally desired to be coddled and catered to by the father and the older brothers. He has had need for more than the usual amount of protection and love from the father.

2. Somnambulism, in its essence, represents to the sleep-walker an attempt to escape from threatening dangers. In the army, these dangers are both real and phantasied, the result of a combat training program in which the soldier must participate to prepare himself for the eventual battle with the enemy. Some of the training factors that reactivated the danger to his ego were firing on the rifle range; going over the landing net, which simulates disembarkment from a ship; going over the battle-conditioning course, which reproduces an actual battle experience, with machine-gun bullets over his head and land mines exploding in close proximity to him; and exposure to various harassing and dangerous gases. This fear, together with the threatening environment in which the soldier finds himself, recapitulates his early experiences of previous danger in infancy and childhood. Somnambulism is really a flight from the above dangers to the all-powerful, strong, safe, and beloved father or father surrogate.

3. The somnambulist participates in a furious conflict between the super-ego and the id, represented by the patriotic and social ideal as opposed to the pleasure and self-preservative instincts—instincts that would save him from possible mutilation or from destruction.

4. These men have all been arrested on a homo-erotic level of psychosexual development, the evidence for this conclusion being as follows:

A. The belittlement and deflation of the rôle of the

mother, with the emphasis on the importance, the mastery, and the perfection of the father.

B. The emphasis on the constant demand for affection and attention from the father or the older brother, who often represents a father surrogate.

C. The flight from parenthood, the indifference and resistance toward making normal heterosexual adjustments, and the large incidence of divorce and marital discord in this group.

D. The tremendous importance placed by these men upon obtaining popularity among their comrades, both in the army and in civilian life. To achieve this goal, they will even indulge in alcoholic excesses.

E. The dream content and activities of the men during somnambulism.

5. Somnambulism is a form of neurosis, with its own peculiar structure and configuration in the constellation of neuroses.

6. In our experience, psychotherapeutic methods were greatly enhanced and expedited by the use of sodium amytal, which permitted us to deal with repressed material, thereby reducing the incidence of sleepwalking to a considerable extent. Our success, however, was tempered by the knowledge that the sleepwalking episodes were often replaced by other anxiety, hypochondriacal, or hysterical symptoms.

Finally, let me emphasize that we make no claim to have cured these men either of their somnambulism or their neuroses, but we did succeed in helping a number of them adjust to the army requirements and situation, which is the objective of military psychiatry.

PSYCHIATRIC REHABILITATION OF REJECTEES AND MEN DISCHARGED FROM THE ARMED FORCES *

THE WISCONSIN SERVICE FOR REJECTEES †

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THE services that are being carried on in various parts of the country in counseling rejectees seem to vary considerably in scope, objectives, and sponsorship. A brief description of the Wisconsin service, to indicate how it resembles or differs from other programs, may, therefore, be of interest.

To begin with, this service is not sponsored by a single agency, but by three—the Milwaukee County Council of Defense, which represents the citizenry of Milwaukee County; the Milwaukee County Community Fund and Council of Social Agencies, which represents all of the health and social agencies in Milwaukee County; and the Wisconsin Anti-Tuberculosis Association, which represents the health interests and agencies of the entire state. It is believed that this sponsorship by several organizations has been of definite advantage, as it has made for a wider and more vital interest.

The service is controlled and directed by an advisory committee, composed of representatives from the three sponsoring agencies, as well as others. These individual committee members represent many of the professional interests in human welfare—namely, medicine, psychiatry, nursing, medical-social work, family case-work, labor, public health,

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† Since this paper was presented, the counseling service described has been discontinued, owing to a variety of developments which impelled the Committee on Service to Rejectees to consider whether the skill and funds devoted to the service should not be transferred to other and more pressing demands. As a demonstration of the need for community mental-hygiene facilities, the committee felt that the purpose of the project had been largely achieved.

research, and the armed forces. The broad experience of the committee members and the coöperation and interest of the commanding officer and the staff of the induction station have been of great importance in the development of this service.

The service is located right at the induction station, which we believe is vitally important, because the moment that a man is rejected seems to be the psychological time to begin helping him to adjust to rejection. Some services are located at Selective Service headquarters, others at draft boards, and still others at agency offices.

Many projects of this type seem to have been on an experimental, short-time basis, running from one to three or six months. Ours has now been in operation a year and a half, and the plan is to continue it for the duration. During the first year, over 12,000 men were interviewed.

Of importance, too, is the fact that it is not limited to any one group. Some projects have been limited to men rejected for tuberculosis; others to those rejected because of psychiatric disabilities. Ours is a voluntary service available to any rejected man who desires it.

We do not presume to give a thorough, exhaustive interview. Our objectives are fivefold:

1. To give the man an opportunity to express his feelings about rejection and to discuss any problem, whether it has to do with rejection, employment, or some family situation.
2. To help the man understand why he is rejected.
3. If care or further study is indicated, to help him understand what and why, and to stimulate him to want to do something about it.
4. To direct him to some one in his own home community who can help him solve his problem—in other words, to act as a steering or reference service.
5. Last, but definitely not least, to try to ease the shock of rejection and help him to realize the importance of the man behind the lines.

We have begun to realize that this last objective is perhaps the most important. Practically all men seem to be emotionally upset over rejection. Even those who did not want to get into service are disturbed. They have their feelings

of guilt. The young boys are bitterly disappointed, unhappy because of the stigma and the fact that their friends are in service. Older men are disturbed over the uncertainty of rejection. Will they be reclassified, or are they permanently rejected? Shall they sell their cars, or break up their homes? Shall they buy new clothes, or will they be in uniform before the old ones wear out? Whether we refer the case to an agency or not, we believe that the opportunity to express his problems and anxieties helps the man to adjust to the experience of rejection and to return to his job and his community better able to carry on.

Only a very brief record is made. Volunteers are used to take identifying information. This was done in the beginning with some misgivings, but our volunteers have been carefully selected and trained and have proved most valuable.

The men come to us directly from the medical department, where the officer at the final check desk, who tells the men that they are rejected, hands them a slip reading: "You have been rejected at this time for service in the armed forces. Present this form at the service desk on the third floor, so that you may learn of the resources in your community where you may secure advice and help."

As stated before, our interviews are necessarily brief. The men come to us from the psychiatrist, who has been direct in his approach. Best results in interviewing have been obtained by continuing this direct approach of the medical examiners. Among other things, an attempt is made to learn how the man feels about rejection, how much he knows about his condition, and whether he was aware of it before examination at the induction station. Has he any other physical disabilities besides those for which he was rejected? Do any of these disabilities interfere with his work or his pleasure?

In the case of those rejected because of psychiatric disabilities, we attempt to learn how his "nervousness" has been manifested. A majority of men indicate that a "nervous stomach" or "jitteriness" or "excessive worry" were the only symptoms of which they had been aware, but they considered these physical and had no realization that they might be associated with the emotions. The family history or pattern in the matter of nervousness, and the man's adjustment at home, at school, at work, and in recreational settings are

also discussed. As would be expected, the majority of men indicate that one or both parents were nervous, and a considerable number relate the usual failure to adjust in school or employment. Finally, vocational and recreational interests and desires for assistance are discussed with a view to leading on to a discussion of reference to an agency.

Throughout the interview, an attempt is made to help the man recognize the connection between emotional disturbances and physical symptoms and to stimulate a desire to take the first step toward treatment or solution of his problems. Experience has proved that careful interpretation of agency service and avoidance of "overselling" is important. If the man goes to an agency overconfident that the solution of his problems can be achieved, agency results are likely to be poor. On the other hand, if the man recognizes the fact that the agency can be of help only to the degree to which he himself is willing and able to accept guidance, agency results are likely to be more successful.

When the project started, for the purpose of our own information, all Milwaukee cases were cleared with the Milwaukee Social Service Exchange, to learn what proportion were known to agencies. It was found that two-thirds were known. Only those cases referred to an agency are now cleared.

At first, we presumed that most men would seek counsel because of physical disabilities. Actually, about 50 per cent of those seeking counsel give "nervousness," as they express it, as the reason; 6 per cent give conditions of the ear; 5 per cent, conditions of the cardio-vascular system; 4½ per cent, hernia; 4 per cent, conditions of the eye; and 3 per cent, tuberculosis.

We believe that the reason why so many men with psychiatric disabilities seek counsel is, first, that they do not understand the condition itself. Second, they do not understand why nervousness should disqualify a physically healthy man. Third, they never realized that they were nervous. And finally, to many of these men who are being disqualified for psychiatric reasons, rejection for military service climaxes a life of one rejection after another. Some of these young men have been rejected by one or both parents. Then they were rejected by teachers, through academic failures and

inability to adjust to school routines. Later they were rejected by employers, through "lay-offs" and dismissals. Some were even rejected by their family physicians, who told them there was nothing wrong with them physically, that their trouble was all mental or imagination. And now they are rejected by their country. To this group rejection is probably a more severe shock than we realize.

What is done about these problems?

Because of limitations of space, those rejected for purely physical conditions will not be discussed here except to say that the great majority are referred to their own family physicians and about 23 per cent to public-health nurses or public-health agencies. There are public-health nurses in all but four or five counties, and clinics or good medical facilities in most parts of the state. As far as physical disabilities are concerned, we have substantially adequate coverage.

The psychiatric disabilities are something else.

Wisconsin, which is advertised as the "Dairyland of America," is, as one would expect, primarily rural. Milwaukee is really the only city in the entire state with anything like adequate resources. In Milwaukee there is a psychiatric clinic, the Milwaukee County Guidance Clinic, and a number of psychiatrists in private practice, but it takes anywhere from four to six weeks to get an appointment at the clinic, which is a considerable handicap. Madison is the only other city in the state with a psychiatric clinic that serves adults as well as children. The state board of health is carrying on demonstration child-guidance clinics in eight counties, but unless the men we interview happen to have problem children, these clinics are of little help to us. There are case-work agencies in about ten counties, but less than half of these have staffs equipped to handle psychiatric problems.

All existing resources are used—public-welfare departments, group-work agencies, and schools, to mention only a few. The interest and coöperation of these various types of organization have been most gratifying. Through the problems of the rejected men and discharged veterans, some communities have begun to recognize their need for psychiatric service, and a few are taking steps to secure it.

In Milwaukee the emotionally ill are referred to the particular agency best suited to serve them. If they have been

known to one of the family case-work agencies, they are referred back to that agency. If they are not known, we may discuss several possibilities and leave it to the man himself to make a choice. Or, if he is too confused and bewildered by the experiences of the day, it is suggested that he come in for another interview in a week or two. Many men do this, and we find that they are then much more ready to accept service. When a case is referred, we give the man a card of introduction and with his permission send a report to the agency in question. About 7 per cent of the total number of men interviewed from Milwaukee County are referred to case-work or psychiatric agencies. Among men from the state, only 3 per cent are so referred. This is because there are so few agencies to which we can refer cases out in the state. These may seem like small percentages—but it must be remembered that many men are normally adjusted to civil life and need no treatment.

An attempt has been made to evaluate these referred cases. The results are not too encouraging, but perhaps not too discouraging if it is remembered that we are still in the pioneer stage so far as psychiatry is concerned. Of the men referred to Milwaukee County Guidance Clinic, 16 per cent actually went in for examination. Of the men referred to one Milwaukee case-work agency, 23 per cent responded. In referring men to this agency, we call the agency and give them the information about the man. They then write him a letter, giving him their office hours and asking him to let them know when he can come in for an interview. Another case-work agency, in one of our smaller communities, writes the man a letter, and if he does not respond, a visit is made. Twenty-one per cent of the men referred to this agency have accepted service. Results, in short, depend to some extent on the attitude, policies, and standing of the agencies.

As indicated before, we were much discouraged over these results until we reminded ourselves that this is a pioneering job. Some twenty years ago, when case finding in tuberculosis was new, we worked with the chest specialists as a team. We would go to a community to stimulate interest, several days before the doctor arrived. It was a real job in those days to get enough people to the clinic to keep the doctors busy—and one doctor could examine only from twenty to thirty

persons a day. People were so afraid of tuberculosis then that they would not go near a doctor—until it was too late.

People are afraid of psychiatrists to-day just as they were of chest specialists twenty years ago. A great deal of stigma is attached to anything remotely resembling mental illness.

What is to be done about it? I would not presume to offer suggestions. But perhaps some analogy can be drawn from what has been done in the field of tuberculosis. To-day almost every school child knows the symptoms of tuberculosis. Almost any man on the street knows them and knows, too, that early discovery means early recovery. Why? Because during the past twenty years every medium of education—newspapers, radio, movies, classroom discussion, and pamphlets—have been utilized to tell every man, woman, and child in the country that tuberculosis is curable if discovered early; that some of the most common symptoms are cough, fatigue, and loss of weight.

As in the case of tuberculosis twenty years ago, people reach psychiatric clinics too late. Many of the rejected men referred to psychiatrists have been presenting symptoms for years. Failure to adjust in school, nervous stomach, sleep-walking, and seclusiveness are only a few of the glaring symptoms that have been overlooked by parents, teachers, physicians, and employers.

In conclusion, it might be remarked that while we feel this counseling service may have been of more value to the individual than can be proved by statistics, we hope also that it has done something toward awakening Wisconsin to the extent of the problem of emotional and mental illness, the tragic lack of resources to meet this problem, and, finally, the great need for education of the general public in matters of emotional and mental health.

In an attempt further to arouse Wisconsin, we submitted the following suggestions in our last report, for the consideration of the people of the state:

1. Careful study of the extent of emotional illness, based on official army statistics on discharges and rejections, when and as these data are available. Recent admissions to mental-disease hospitals might be another source of information. The careful study

of children who are failing in school or finding it difficult to adjust might furnish still another source of information on this subject.

2. Recognition of the need for education of the public on this whole subject of mental and emotional health, emphasizing the early symptoms, the need for expert advice, and the fact that mental and emotional illnesses are treatable—and preventable.

3. Study of the possibility of expanding the services to meet the post-war need. The dearth both of psychiatrists and of psychiatric social workers is recognized as a serious obstacle in the solution of this problem. Training of professional personnel is, therefore, one of the greatest problems in expansion of services.

4. The establishment of programs in our educational system, designed to give the child an understanding of his nervous or emotional system and how to use and control it.

5. The establishment of a system of traveling mental-hygiene clinics. While such a set-up would probably not constitute an adequate substitute for well-staffed and permanent clinics in urban centers, it might well serve as a demonstration service of far-reaching value and may be the only feasible type of service for rural areas.

In a word, then, we think we have worked out a practical procedure for guiding young men rejected for service in the armed forces to remedial resources in their own communities. While many may have reached these agencies too late to be helped, perhaps our demonstration will have assisted in developing needed programs of prevention.

INTERVIEWING THE RETURNING SERVICE MAN

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THE returning service man is the present "cause" of social work, in fact of all socially minded people in the country. Just about four years ago, when the blitz was reaching its

height, social workers and the charitably minded public were involved in another "cause," the evacuation and reception of British children. Somewhat later, the day care of children captured the national interest, much of which it still holds, although juvenile delinquency is running it a close second.

By citing them together, I do not mean to imply that all these causes were of the same national importance. I think, however, that they are similar in that they all put heavy demands on social workers and challenged them to bring their best thinking and skills into play for the benefit of the groups on whom the interest was focused.

Sometimes it has been difficult for social workers themselves to keep their feet on the ground and to avoid being caught up in the popular stream. I recall particularly how the idea of bombs over Britain caused many experienced case-workers to forget momentarily what they knew about the worse hazards of parent-child separation. For a time they lost their professional objectivity and pressed for mass evacuation which, had they paused to think, they would have realized was psychologically unsound.

Lest we fall into a like trap on behalf of the returned service man, I think we should pause to remember that the fact that he has been in service does not necessarily change his patterns of thought and behavior. He is not *different* from another man who has had an unusual and shocking experience. Therefore, if we can be guided by what we have learned about human beings in general, we shall be on the safe side in helping the returned man. We shall not mark him as "different" because he has been in the army or the navy or the Marine Corps, nor shall we consider him similar to other returned men for the same reason.

Case-workers, more than any other group of social workers, have concentrated on understanding the individual. From their study and experience they have gained much knowledge of human behavior as well as skill in helping people. It is on this reservoir of professional experience that the public can most profitably draw. Likewise it is this knowledge that we can put to dynamic use on behalf of the returned man.

In January of this year the veterans' representatives of the United States Employment Service in Connecticut held a conference in Hartford. They invited organizations interested

in returned men to present their programs. Thirty-two organizations responded. Each had a plan, showing how its particular service or services would be made available to the ex-service man. But while the plans looked very efficient and interesting on paper, there was little material to indicate how helpful they would be at the operating level. In other words, they seemed to be based rather on anticipated needs than on those that had been demonstrated. Moreover, specific problems seemed to be anticipated in relation to the particular interests of the agencies that put forth the plans.

I feel sure that Connecticut is not alone in this situation and that other states have as many or more organizations wanting to help without too much actual knowledge of what the ex-service man's needs are or will be. It is at a point like this that case-workers can be particularly useful in helping to determine actual needs, and that is why the Greenwich experiment of having a case-worker interview men as they returned was begun.

In Greenwich, Connecticut, the community is closely knit, though it includes a large area. It was only natural, therefore, that organizations interested in the returned man should get together for purposes of unifying their efforts to help him. The Community Council, the American Red Cross, and the Selective Service board jointly sponsored a Committee on Reëmployment and Rehabilitation. Its membership—sixteen in all—included representatives of labor, industry, veterans' organizations, the clergy, and social agencies.

At its first meeting, after having elected as its chairman the head of the Selective Service board, the committee decided to try to discover what the returning service man wanted before setting up devices to help him. As a result, the private case-working agency in the community was asked to lend a staff member to the committee for three months.

It was decided that she should be stationed at the Selective Service board, where all returning men must report for reclassification upon discharge. She was asked to try to discover what the individual man returning to Greenwich wanted and needed. How was he going about getting it? Was he chiefly interested in employment? In further training? In obtaining medical care? In readjusting himself to civilian life? In short, would it be possible, through skilled

interviewing of the returning service man by a person educated in case-work, to get some idea of what might be anticipated for the future and at the same time to help the man who is returning now to avoid the traditional run-around?

This method of approach was soon taken up by two other Connecticut communities—Hartford and Stamford. The auspices differed—in one instance it was the council of social agencies, in the other the reëmployment division of the town rehabilitation committee. But in all the experiments case-workers were stationed at the draft boards—five boards and four case-workers in all. Also, in every instance the case-worker was chiefly responsible to the reëmployment committee man of the Selective Service board.

Because the ventures began at a different time in each place, I have not been able to assemble uniform statistics. I am basing my discussion on interviews with 96 returned men—14 from Stamford, 27 from Greenwich, and 55 from Hartford. Thus you will see that the smallness of the group prohibits the assumption that any definite trends prevail. That is why I hesitated greatly before giving this paper; I felt keenly that we knew so little. The volume of cases is small, the time is short, and the type of man now returning and the problems confronting him are obviously very different from the ones we shall see a year from now. Thus, anything I say is tentative. To underline this, I should like to point out that of the 96 men interviewed, only 21 had seen foreign service, a ratio that will undoubtedly change soon. Moreover, few had fully established service-connected disabilities, though some had ailments that had been aggravated by service. Also, length of service was not great—32 of the 68 men seen at two of the boards had been in the army or navy less than a year.

One thing that may be significant is that these 96 men did not necessarily want what the public expected them to want. Current favorable labor conditions are not the only reason for the low place on the list of requests for immediate employment. Many men want a vacation first of all, or they want medical care in preparation for a job later. Some want help in interpreting to their families and friends the reason why they were discharged. Others want help in handling themselves in relation to their families.

Needless to say, the expressed request is not necessarily

the real one, and often it has turned out at the end of an interview that a man has decided to accept reference to an agency that he and the case-worker have mutually decided will meet his need rather than the more highly advertised one he thought he wanted when he came. Interestingly enough, few of the references have been made to vocational-testing centers—nine in all—and only three have been made to family case-work agencies. Since both have been widely publicized as helping returned men, it is interesting that case-workers who are familiar with the services these agencies have to offer have not found the men ready to be referred to them. This may in the long run save much time and money and put the agencies to their most constructive use on a selective basis.

In discussion with the case-workers who are doing the interviewing, I have found that there is unanimity of opinion regarding the value of the service to the returning men. They think that it helps him to have immediate attention given to him as an individual. One man commented favorably on the appointment system, saying that it was wonderful not to stand in line. Others have expressed gratitude for the consideration given them and in several instances have written letters saying how much the "good steers" have helped. The case-workers see the work as a diagnostic reference service. They find their experience in intake and sensitive use of community resources particularly valuable. In no sense do they see themselves as a new treatment agency, but rather as a sifting and referring service wherein their case-work skills in diagnosis are marshaled to the utmost.

It is my opinion that it takes a particularly skilled case-worker to do the job adequately. He must be quick to sense the problem that is pressing to express itself and he must be able to help bring it out at once, for he will seldom have a second chance. He must be able to see behind the immediate verbal request as did the worker who interviewed Mr. S.

> Mr. S.'s one stated wish was to reënlist. That was all he wanted help with. Would Miss E. just show him the ropes and maybe pull some strings for him? Actually Mr. S. was a very disturbed young man, and Miss E. realized this from observing his mannerisms, his speech, and his movements as soon as he entered the room. His real problem lay in his inability to accept the fact that his emotional instability had caused his discharge. What he *needed* was medical and psychiatric care. There

was no hope of his being reaccepted by any of the services. Already several influential people, mistaking his ardor to reënlist for healthy patriotism, had reinforced it by agreeing with him that he should get back in the service.

The case-worker helped him articulate his real fear—that of finding out what was really the matter with him. That was what he was running away from by striving, against hopeless odds, to reënlist. The worker, by helping him bring this out in the open and reassuring him that help was available, was successful in alleviating his anxiety to a point where it was possible for him to accept reference to the resources he needed.

Had the worker taken his expressed request at face value, she would not have been able to establish a helping relationship with him. She would have been but another stop on the "run-around." This kind of diagnostic skill and an ability quickly to form a relationship that the man can use constructively are essential qualifications for case-workers doing this job. It was by no means a coincidence that Mr. S., and indirectly the community, benefited. It was the skill, background, and experience of the worker that enabled her to be truly useful to him. Possibly skilled supervision of the worker interviewing Mr. S. might have brought about comparable results, but it would probably have taken longer. Such a method is being currently tried in some communities where the most experienced workers cannot be spared to do the actual job. The experiment, however, is new and so far no evaluation of the results can be made.

It is questionable whether properly equipped workers will ever be available in sufficient volume to allow for a general establishment of services such as I have described. This does not, however, detract from the very real contribution that is being made. We are learning something about the needs and wishes of the men now returning. We are observing the changes brought about in them by service and by discharge. We are seeing that the community and the man do not always see eye to eye about what he wants. Already this knowledge is beginning to bear fruit. In the communities where the service has been offered, there is some modification of plans for accommodating the returned man. There is a greater tendency to see him as an individual with his own particular needs and his own ideas of what he wants to do about them.

We still have a long way to go, for community attitudes change slowly, as we all know. Because of the great and deep interest in returning men, the workers offering individualized

services to them are in a position that, from the point of view of the profession as a whole, is at once enviable and precarious. One mistake often speaks louder than ten successes and the public are apt to hear of the former first. It follows that in addition to training and proven skill the workers must possess professional security and fortitude to a degree that will enable them to stand firmly on their professional judgment and interpret their reasons for so doing in a language that the community can understand. They are doing the same job as always, but it is high-lighted by a burning national and local interest. By keeping a true sense of perspective and drawing constantly on their reservoir of knowledge about human beings in general, case-workers can make a very real contribution to the well-being of men returning from service.

STATE AND LOCAL PLANNING IN THE LIGHT OF FEDERAL PROVISIONS AND CLINICAL EXPERIENCE

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IT is clear from Miss Paull's paper that a high percentage of men rejected for duty in the armed forces are in need of some kind of psychiatric or social treatment. The preponderance of those who had some psychiatric or personality problem was impressive. The problems of discharged men, as reviewed by Mrs. Gregory, are obviously valid and point to similar service needs. The pre-induction examinations of millions of men, and the further sifting and testing by experience in the armed forces, again reveals a tremendous need for psychiatric and social rehabilitation. National figures are truly impressive. Over four million men from eighteen to thirty-eight years of age have been rejected for one reason or another. One and a quarter million of them, or 10 per cent of all who were examined and 36 per cent of all who were rejected, have some mental or emotional handicap that is believed to make them unfit for military service. Moreover, of the more than 800,000 men who have received medical

discharges from the armed forces, an estimated 40 or 45 per cent were discharged for some neuropsychiatric condition. Reliable estimates place the number of such, thus far, at 300,000 or more, and current monthly additions at from twenty-five to thirty thousand.

The degrees of illness and maladjustment range all the way from advanced psychoses to very minor maladjustments. Only from 6 to 8 per cent of psychiatric discharges seem to need hospitalization, and, according to official figures of the Veterans Administration, 48 per cent of these recover sufficiently to be discharged from the hospital by the end of the second month. Some are able to work, others are not. Many of the latter work under a considerable strain, and are far from happy in their adjustment. The experience of family and children's agencies indicates that many who are essentially normal in their psychological make-up are faced with real problems of family adjustment, and from various sources there is indication that almost all discharged men have some adjustments to make in getting back into the swing of civilian living. Some rehabilitate and readjust themselves quickly, but it is pretty clear that sizable numbers are going to need some professional assistance, at least for a short interval.

Governmental Provisions.—The government has made several helpful provisions, and legislation about to be enacted will make still further provisions for veterans.

1. Through the Reëmployment Committees of the Selective Service System, men who wish to return to their former positions are assured of being restored to these positions, and all who want other positions are provided with placement opportunities through the United States Employment Service. At the present time these provisions seem quite adequate and virtually assure employment to all veterans able to work.

2. Hospitalization is provided through the Veterans Administration for all those who need it. Priority is given to emergency cases and to men whose disabilities are service connected, but thus far most veterans who need hospitalization have received it. Those who are unable to work, or who are somewhat handicapped, on account of service-connected disabilities, are also eligible for pensions ranging from $11.50 to $115.00 a month, depending upon the percentage of dis-

ability rating received, with additional amounts for care of dependents.

3. Vocational retraining for veterans with a 10 per cent or greater handicap is provided for men with service-connected ratings by the Veterans Administration, with maintenance during retraining, medical care, equipping with necessary tools, job placement, and follow-up.

Civilians and ex-servicemen who do not receive service-connected ratings may apply for vocational retraining through the various state bureaus of vocational rehabilitation.

In most states the mentally handicapped, as well as those with physical disabilities, are now eligible for vocational retraining and for medical and psychiatric services, if the diagnosis indicates a handicap that partially limits the man's employability, and if the prognosis indicates likely improvement through vocational training or medical, psychiatric, or social services. The federal government pays the administrative cost and 50 per cent of the service and training costs of the state vocational bureaus.

4. Legislation which appears quite certain of enactment in the near future will provide for the continued education of veterans who want it, and also will make available loans for home and farm purchase, establishment in business, and other forms of economic assistance.[1]

Lacks in Governmental Provisions.—Helpful as these provisions are, it is clear that there are some lacks:

1. They do not provide an adequate amount of out-patient treatment, especially for those who have handicapping psychiatric conditions that do not require hospitalization. Since the Veterans Administration has thirty neuropsychiatric hospitals, sixty-four general hospitals, and fifteen regional and district offices located at other points, an increased amount of out-patient treatment through that agency would be possible, if adequate provision were made for staff at all of these points. As a field consultant who has been in half the states in the last four months, I have no hesitancy in saying that this need for out-patient treatment is by far the one most frequently mentioned as an outstanding need.

2. The government does not coördinate our various civilian

[1] See Public Law No. 346, passed by the 78th Congress.

services in states and communities, except for the special effort of the War Manpower Commission to do so experimentally in five of our cities.[1] Properly to coördinate all agencies interested in veterans and to avoid confusion is clearly a mammoth task, considering that in some states twenty-five or more distinct organizations claim to be giving service to veterans.

3. The government does not survey existing community facilities and plan for new or additional services for the unmet needs.

4. To date, at least, the government has not attempted to educate the public regarding the needs of various groups of veterans. A case in point is the lack of effort on the part of governmental agencies to create a more favorable attitude toward men discharged from the armed forces for psychiatric conditions. The handicap of this group on account of the tendency to stigmatize them is very real.

5. While federal, state, and local governments have given considerable attention to post-war planning in terms of creating and maintaining jobs, it is clear that much of this planning will have to be done by private industry and community groups.

Needs as Revealed in Clinical Experience.—While social workers throughout the country have been observing in recent months that there is marked need for case-work and clinical treatment of many men returning from the armed forces, relatively little systematic study of this need has been made. A number of rehabilitation clinics have been organized in recent months, and case-work agencies are giving service to increasing numbers of veterans and their families. Almost nothing on the subject has been published so far. A summary of the results of psychiatric treatment of the first two hundred men seen at the New York Hospital Rehabilitation Clinic will serve to give some indication of the needs of veterans discharged for psychiatric reasons.

Dr. Thomas A. C. Rennie, Director of the Rehabilitation Clinic and of the Rehabilitation Division of The National

[1] Subsequent establishment of the Retraining and Reëmployment Administration, under the direction of General Hines, coördinates the work of the Selective Service System, the Veterans Administration, and the U. S. Employment Service, as these relate to the retraining and reëmployment of veterans.

Committee for Mental Hygiene, states that the problems facing these men on their return home are surprisingly alike: a sense of stigma over their psychiatric discharge, a need for proper employment, lack of companionship and recreation, uncertainty as to how to explain their return home, family overconcern or rejection, ignorance of compensation procedures, a feeling of being neglected, and, of course, varying degrees of disability, due to their unresolved psychoneurotic or psychotic symptoms.

One hundred and sixty-two of these men have been discharged from various branches of the armed forces; one man is still in the army, stationed at a nearby camp; and 37 were rejected at an induction center. Twenty-four of the men had seen foreign service, of whom 14 had been in actual combat. One hundred and ten were in their twenties and 72 in their thirties. As to cultural and social backgrounds, they range from a lieutenant colonel and a lieutenant commander to privates with sixth-grade education and foreign-born citizens.

As to type of problem, 54 per cent were suffering from one or another type of psychoneurosis, anxiety being the most common symptom. Only two of the two hundred have had the so-called "battle neurosis." There were small numbers of hypochondriasis, hysteria, and obsessive-compulsive neurosis. Twelve per cent were diagnosed as psychopathic personalities, and 11 per cent showed schizophrenic reactions. Manic-depressive reactions were found in 5 per cent, 3 per cent evidenced overt homosexuality, and 3 per cent were mentally defective. Sixteen per cent in all were frankly psychotic, and most of them were in need of hospitalization, which was refused by a majority.

In 64 per cent of the total group, their illnesses developed within six months after induction; in 42 per cent illness occurred during the first three months of training; and in 10 per cent after less than one month of service. Thus the majority of these men were predisposed to a rapid breakdown under the circumstances of army training. The pre-induction histories of these men indicate that most of them showed personality difficulties long antedating their military service. Seventy-four per cent of them gave a history of previous personality problems, and a number of them had been hospitalized or had received psychiatric clinical treatment prior

to induction. In 21 per cent there was no clear-cut evidence of previous personality difficulties.

All but one of the 37 men who had been rejected at the induction center were seriously involved individuals. Seven had schizophrenic psychoses, and two were suffering with depressions. The remainder had severe psychoneuroses. Rejection was a surprise to only four of them.

In a follow-up inquiry, some statement about the current status was obtained concerning 179 out of the total 200. In 58 per cent, the clinic staff feels there has been definite improvement in the men's conditions, and an additional 5 per cent appear to have gained some help from the clinic. In 40 per cent improvement is very marked.

Dr. Rennie further notes that the specific feature of genuine interest in this work is the amount of constructive therapy that can be accomplished in a relatively brief period of time, and in some instances with men whose conditions are really severe. It is evident that some discharged men are achieving their own rehabilitation spontaneously, without help. Another large group is helped in one consultation, aimed at orientation toward discharge, discussion of resentment, help in making social contacts and finding appropriate employment, and general supportive reassurance. In a group of 70 men who described themselves as well, symptom-free, or much improved, a third were seen only once, and about two-thirds of the group were not seen oftener than three times. About one-fourth needed repeated and brief interviews, and in some, of course, prolonged psychotherapy is necessary. The psychiatric social worker's assistance in interpreting the situation to the family and finding appropriate recreation and proper job placement are essential features in the successful treatment of many of the men.

Planning at State and Local Levels.—In the light of the problems that rejectees and discharged men present, the provisions that have been made by federal and state governments, and the results of psychiatric and social treatment where these have been attempted, there is need for further planning along five lines:

1. There is need for concerted effort to increase the public's understanding of the nature of the disabilities on account of

which men have been rejected or discharged from the armed forces. There is a marked tendency to regard these men as generally or totally unfit; whereas in reality their handicaps are rather in the nature of specific vocational limitations. Just as not all men would be adequate as musicians or mathematicians, so not all have an aptitude for military service and the numerous adjustments required. The need for better understanding of psychiatric disabilities is particularly acute, as the men feel stigmatized, and many employers and the families of many men are unduly alarmed about psychiatric rejections and discharges.

The National Committee for Mental Hygiene and various other mental-hygiene and psychiatric groups are planning additional efforts along this line. Every local community, however, will have to add its share to this effort to increase public understanding. A memorandum prepared by The National Committee for Mental Hygiene has been distributed rather widely to planning and coördinating social-agency groups, and in some places courses are being put on in industrial plants and with community groups.[1]

2. A sound and economical system for referring veterans should be established in every major community. In some places this is being done by way of simple, but psychologically sound, informational pamphlets, which are placed in the hands of men as they return. An increasing number of communities are establishing veterans' service centers, staffed by trained and experienced interviewers, who explore the veteran's problems with him sufficiently to determine what his basic difficulties are and to make a correct reference of his case in the first instance. This seems to be one very helpful way of avoiding "the run-around" for veterans. "Run-arounds" must be avoided, for they quickly add to the confusion and cause justifiable resentment. Agencies could muff their opportunity quite completely by failing to get men to the agencies that can effectively serve them.

3. Many communities will have to plan some new and additional services to take care of unmet needs. One of those

[1] See *When He Comes Back* and *If He Comes Back Nervous*, two talks to families of returning service men by Thomas A. C. Rennie and Luther E. Woodward, published together in pamphlet form by The National Committee for Mental Hygiene.

most commonly needed is out-patient psychiatric treatment and social-work guidance in dealing with problems that are partly psychiatric and partly social in nature.[1]

4. In most communities there will be need for planning programs of coöperation between industries on one hand and the professions of psychiatry and social work on the other. The significance of proper employment is obvious. Employers and industrial leaders are genuinely interested in giving maximum employment to returning service men, but they are somewhat frightened by the high incidence of discharge for psychiatric reasons and feel a definite need for help in properly placing these men and in dealing constructively with them on the job. Time is lacking to describe specific programs along this line.

5. In most communities there will have to be further planning of sound and democratic organization for coördinating the communities' resources and services, and for implementing new undertakings.

[1] For suggestions regarding the organization of special rehabilitation clinics, see "A Plan for the Organization of Psychiatric Rehabilitation Clinics," by Thomas A. C. Rennie. MENTAL HYGIENE, Vol. 28, pp. 214–23, April, 1944.

THE MENTAL-HYGIENE-UNIT APPROACH TO RECONDITIONING NEUROPSYCHIATRIC CASUALTIES *

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THE mental-hygiene unit, composed of the clinical team of military psychiatric social workers and military clinical psychologists functioning under the direction and supervision of a military psychiatrist, has been found to be the most effective means of qualitatively evaluating and treating the total personality of the soldier, physically, emotionally, and intellectually.[1] In the adaptation of the clinical team's professional disciplines to the more complicated problem of the neuropsychiatric casualty, it became necessary to modify already tried methods and to create new techniques. The basis of the unit's approach has been an understanding of army standards and the problems in which the personality becomes involved in attempting to meet, as an effective soldier, the pressures of military service. It was with this focus in mind that the mental-hygiene unit

* *Note:* After functioning for two years in the Eastern Signal Corps Replacement and Unit Training Center at Fort Monmouth, New Jersey, where it worked with soldiers presenting problems of adjustment to military training prior to combat experience, the entire mental-hygiene unit was transferred to England General Hospital, Atlantic City, New Jersey, to work out a plan and program for reconditioning the neuropsychiatric casualty. In July, 1944, the director, with the mental-hygiene unit's chief psychiatric social worker, was transferred to Camp Plauche, to organize and develop the mental-hygiene unit program there; and in October, 1944, the remainder of the original mental-hygiene unit staff was transferred to the newly organized convalescent hospital at Camp Upton, Long Island, to continue with the program described in this paper.

[1] See "The Unique Structure and Function of the Mental-Hygiene Unit in the Army," by Major Harry L. Freedman, M.C. MENTAL HYGIENE, Vol. 27, pp. 608–53, October, 1943.

reorientated its approach to helping soldiers in relation to their problems in the army.

In the process, the psychiatric social worker's orientation to the army has been instrumental in developing techniques of group therapy which are embodied in the military group-therapy program, a discussion of which becomes a substantial portion of this report.

The Therapeutic Setting.—The soldier admitted to the mental-hygiene unit is one who has developed personality problems that render him incapable of performing the job to which he *had been* assigned. The symptom picture of the psychoneurosis can, therefore, be viewed as an indicator of the degree to which the personality weaknesses of the soldier have been further impaired. Since the primary objective of a reconditioning program is to return men to useful military service, it becomes the responsibility of this installation to create a military environment in which the soldier who has broken down can regain the personality strength that had made it possible for him to perform duty.

With this in mind, the mental-hygiene unit developed a military environment along the standardized lines of military organization which, in a measure, simulated a "trial of duty." In this way a setting was created that would act simultaneously as a diagnostic, educational or reëducational, and therapeutic center. Here, the soldier who cannot meet the minimum military requirements is readily recognized as being too ill to perform any useful service, and final evaluation proceeds toward expediting discharge. Likewise, the soldier who begins to show capability for duty can be encouraged and helped in this environment until such time as he achieves sufficient strength and confidence in his ability to perform a military occupational specialty, within his limitations and potentialities.

The status of a soldier in this therapeutic company is somewhat of an anomaly. It is that of a soldier-patient. The first step from the hospital atmosphere to the company is taken in a quasi-duty status. The soldier is, to all intents and purposes, living under standardized military organization, except that the mission of the company is fundamentally under the supervision and direction of the director of the mental-hygiene unit. The orientation of the activities of the

soldier in such a company makes it possible for those who may have experienced the ill effects of prolonged hospitalization to discover strengths within themselves that are or will become the foundation for eventual return to duty. It represents the first step forward from a period of psychosomatic or psychoneurotic invalidism.

Coördination of the Company with the Mental-Hygiene Unit.—In order to carry out the therapeutic mission of the company, the closest possible coördination of the work of the mental-hygiene unit with the administration of the company commander is imperative in every individual case. It is, therefore, necessary that the company commander be given as extensive an orientation to the mission of the unit as is practicable. It is basic that each soldier be viewed as an individual whose problem requires distinct understanding. This is readily accomplished through frequent conferences between the company commander and the various members of the mental-hygiene unit, as problems arise in each case. All aspects of the company's program are discussed in detail, to meet the special requirements of this group of soldiers. Such questions as that of disciplinary action are taken up on this basis, so that, whatever course is followed, it can become a constructive measure in the soldier's reorientation to duty. The principle becomes the recognition of the need for a military atmosphere to which the soldier must adjust if he is to return to duty. Violation of this principle would defeat the purpose of "trial of duty."

In view of the purpose for which the company has been established in the treatment of the neuropsychiatric casualties, the need for close liaison cannot be overemphasized. In the individual study and treatment of the soldier, the focus becomes the helping process by which the soldier is brought to the point of return to duty. In this process, problems that the soldier recognizes may become important in his adjustment to the company, and are transmitted to the commanding officer by the military psychiatric social worker.

Conversely, in the company program, where the soldier enters into activities under supervision and observation, much is learned about the soldier's capabilities and limitations. Such observational data become a realistic basis for the pro-

gression of treatment upon which further specific recommendations for future military duty may be made. When any special problems are observed in this way, they are transmitted to the mental-hygiene unit and can be treated on an individual basis.

The coördination between the clinical and the company settings, as can readily be seen, is the *sine qua non* of the mental-hygiene approach to the reconditioning of neuropsychiatric casualties. Herein, the clinical team has combined its techniques to function in relation to a therapeutic company for the purpose of using a reality situation to determine when a soldier has recovered sufficiently for return to duty.

The Rôle of the Psychiatrist or Director of the Mental-Hygiene Unit.—The psychoneurotic casualty is primarily a medical problem. In a soldier who has become sufficiently ill to be unable to continue in the performance of his duties, the entire effort of diagnosis, treatment, and disposition, therefore, logically falls within the field of military psychiatry. Here the psychiatrist, whose understanding of emotional illnesses makes it possible for him to exercise this responsibility, engages in his profession with a maximum of professional competence as a military psychiatrist.

The military psychiatric social worker, already trained in this type of treatment in civilian life under a psychiatrist's direction, here again is the psychiatrist's chief aid in carrying out a well-organized military therapeutic program.

Specifically, the psychiatrist's responsibility, as director of the mental-hygiene unit, in dealing with the psychiatric casualty, falls into several areas. Administratively, the psychiatrist must maintain liaison with all sections and hospital facilities available to him. He must understand the function of each specialized medical service and know how to use them efficiently. In order to accomplish this, he must be familiar with army policies, procedures, and appropriate forms. He must be able to deal with routine administrative matters quickly and efficiently and must understand the proper use of channels. This is especially important for the psychiatrist, who should presumably devote as much of his time as possible to matters of diagnosis, treatment, and disposition, all of which require the highest degree of professional competence.

In addition to purely administrative problems, the director of the mental-hygiene unit must act as professional leader of all personnel assigned to him—military psychiatrists, military psychiatric social workers, military group therapists, and military psychologists. He must be able to coördinate the activities and special skills of his staff toward a smooth, integrated working relationship that will achieve a well-rounded program.

The psychiatrist supervises individually, either directly or indirectly, the handling of each case. He is available at all times to the military psychiatric social workers for consultation on questions of diagnosis and treatment. He evaluates individually the treatment given to each soldier before making final disposition, either toward return to duty or toward discharge. In as much as the psychiatrist's job is a medical responsibility, it is important that he exercise this at all times. The responsibility for all decisions for medical diagnoses belongs to the psychiatrist. It is for this reason that he must maintain the close supervisory relationship to his staff.

From the point of view of treatment, the psychiatrist, as director of reconditioning psychiatric casualties, holds a very important place in the eyes of the patient, who knows at all times that final decision as to what is going to happen to him rests with the medical officer. For example, a psychiatrist must see each patient on arrival, at which time he has an opportunity to screen out quickly those who are obviously not amenable to treatment within this installation. In addition, he has consecutive contacts with all cases one or more times weekly because of his administrative and medical responsibility for all patients in the mental-hygiene unit.

Having a thorough knowledge of his staff and the capacities of each worker, the psychiatrist is able to delegate varying degrees of treatment responsibility to them in such a manner that the total job can be handled both qualitatively and quantitatively. Above all, it is necessary for the psychiatrist to recognize limitations of treatment in the army, as well as the fact that, because of limited personnel and large numbers of patients, new methods must constantly be evolved to meet the tremendous responsibility of caring for this type of patient.

The psychiatrist will not be able to engage in long-term treatment or lengthy treatment interviews. His approach must be functional in that his orientation is always toward the army—that is, the individual soldier's problem in relation to the army. It is the psychiatrist's mission to return to useful duty as many men as possible, as well as to recommend for discharge as many men as cannot continue in military service. This twofold responsibility carries with it a therapeutic orientation for the soldier himself, since those who are able to return to useful duty are, in equal measure, helped to regain a sense of usefulness to themselves, whereas those who are discharged are often saved from further incapacitating breakdowns while they are still able to serve constructively as civilians in the war effort.

The Treatment Program.—It is the function of the mental-hygiene unit to return to duty as many soldiers as are amenable to treatment. The unit makes recommendations for discharge or duty assignment on the basis of the individual problem, in coördination with military standards of performance.

The soldier would not have been placed here if a question of his suitability for further duty had not arisen. He has been diagnosed as having a primary problem of emotional disturbance, generally brought on through an emotionally traumatic experience in duty. It is recognized that the interfering problem must be removed or a realignment made that is in harmony with the individual's problem and army requirements of him before a valid statement for duty or discharge can be made. It is as important to return men who can be useful in the service as it would be costly to keep those who are unfit.

The program proceeds from the belief that a soldier's emotional problem, which interfered with duty, cannot be treated in the army when he is amenable only to treatment involving long-time deep psychotherapy. To treat a soldier's problem for the purpose of treatment, *per se,* would appear to go beyond the bounds of military mental hygiene. Since the unit's mission is directed toward return to duty or recommendation for discharge, treatment of soldiers emotionally unable to perform duty is guided by two prerequisites: (1) that the treatment required be of a reasonably short period, approximately six weeks; and (2) that the treatment

be geared to military content for the purpose of return to duty, where possible.

Treatment is concentrated in the work of the military psychiatric social worker and the military group therapist, under the supervision of the psychiatrist.

The Rôle of the Military Psychiatric Social Worker.—The military psychiatric social worker in the mental-hygiene unit has been trained to understand the nature, varieties, and motivation of human behavior. His basic skills in assisting in diagnosis and treatment are here adapted to the needs of the neuropsychiatric casualty.[1] In all cases, orientation is geared to helping the *individual* soldier by various techniques which are created to meet the unique problems he presents. Below is quoted a statement of the job specifications of the military psychiatric social worker as defined by army directive.[2] Utilizing these duties as "guides," the military psychiatric social workers in the mental-hygiene unit have flexibly and creatively related their skills to the neuropsychiatric casualty.

The job specifications of a military psychiatric social worker (SSN #263) are officially defined as follows:

> "Under supervision of a psychiatrist, performs psychiatric case-work to facilitate diagnosis and treatment of soldiers needing psychiatric guidance.
>
> "Administers psychiatric intake interviews, and writes case histories emphasizing the factors pertinent to psychiatric diagnosis.
>
> "Carries out mental-hygiene prescriptions and records progress to formulate a complete case history.
>
> "May obtain additional information on soldier's home environment through Red Cross or other agencies to facilitate in possible discharge planning.
>
> "Must have knowledge of dynamics of personality structure and development, and causes of emotional maladjustment."

The military psychiatric social worker in the mental-hygiene unit utilizes his skill under direct supervision of a psychiatrist in collaboration with the military group therapist in the treatment of the total personality as it relates to the soldier's problems and potentialities for army functioning.

[1] See *Psychiatric Case-Work as a Military Service*, by Technical Sergeant Frank T. Greving, A. U. S., and Staff Sergeant Myron J. Rockmore, A. U. S., to be published in MENTAL HYGIENE, July, 1945.

[2] See letter, File AG 201.6, 18 October 43, OC-A-EZ-MB-A, War Department, Washington, D. C., 1 November, 43. Subject: "Revision of specifications serial numbers—AR 615–26, page 9, Psychiatric Social Worker, SSN #263."

The objectives of the military psychiatric social worker are to evaluate the soldier's present behavior, attitudes, and symptoms as they have been and are being manifested toward the army, in order to determine what is blocking his effective functioning and what may be expected of him. The soldier's civilian social adjustment, as well as his previous military accomplishments or lack of them, are considered with him.

In the treatment of the psychoneurotic, the mental-hygiene unit has been concerned with two types of casualty. Primarily the military psychiatric social worker has oriented his skills toward understanding and giving effective help to the returned overseas soldier; secondly, he has worked with the psychoneurotic who has manifested his inability to function effectively while in training, or while on duty in the United States.

The soldier who has been overseas and been returned as a neuropsychiatric casualty presents particular problems. In considering what has happened to him as he comes back in a state of anxiety or with a conversion symptom, it is important to recognize the pressures that produce many of his attitudes. In all the phases of military life, he has been geared for activity related to combat. In basic training, in advanced and amphibious operations, and in overseas maneuvers, he has been geared to activity as part of a unit for a specified objective in combat.

In one sense then, subjectively, the army becomes narrowed down to what his part is in relation to the certain units with which he has identified. Thus his drives, his objectives, and his loyalties become channelized in the form of a specified assignment as part of a larger group. At the same time, this identification with his unit helps him to bear his fears, doubts, and uncertainties better than he might otherwise be able to do.

To the soldier, therefore, the army becomes the particular unit with which he is affiliated. It is quite common to overhear a returned soldier state, "My outfit is the best damned outfit in the whole army." Thus, the soldier is made ready for battle in terms of his training and identification with his unit.

In one degree or another, all human beings can withstand a certain measure of pressure and shock; and each of us

has his breaking point without necessarily being a psychoneurotic to begin with. In varying proportions, each soldier can stand up to battle for either a shorter or a longer period of time without breaking down.

When the soldier "cracks up" on the battle field or while awaiting combat, with the concomitant anxiety thereof, he is immediately withdrawn from his unit. If he is able to return to his unit, the probability is that the chronic developments will tend to be of a minor nature.

If, however, it is determined that the soldier is no longer suitable for combat and should be returned to the States, he faces a much more difficult situation. He "loses" his unit and, with it, a portion of the strength that sustained him. He is no longer physically part of a team. His buddies are going on without him. At the same time, psychologically, his mind and his emotions are still geared to the unit. As a result, contradictory forces begin to heighten his conflict. The further he gets away from the battle front and his unit, the more aggravated these opposing forces become. He may then go from hospital to hospital as he proceeds to the rear, never part of a unit, always as an *individual* who is *sick*. This further increases his emotional conflict and therein conduces to the chronicity of his illness.

Thus it can be seen that when the psychoneurotic casualty comes to the mental-hygiene unit from overseas, he may be in a state of resentment and suffering various degrees of confusion in regard to the army and "what it has done to me." Faced with this type of soldier and his problem, the military psychiatric social worker develops some perspective in his initial contact as to the possible potentialities of the soldier-patient. In line with the mental-hygiene unit's mission, most time is devoted primarily to those men who show treatable signs and who are most likely to return to duty.

Treatment by the military psychiatric social worker takes the form of "counseling." Simply defined, counseling is a series of interviews with the soldier-patient which aims to provide him with assistance in changing his attitudes and behavior in relation to army realities. This provides an opportunity for him to talk out, talk through, become aware of, and integrate his personal preoccupations and fears—reasonable and unreasonable. In this process, the military

psychiatric social worker is always identified with army objectives, as well as with the soldier's feelings and basic attitudes. The soldier's gripes, frustrations, resentments, bitterness, and basic uncertainty are understood and accepted by the social worker. Often, patients have been engaged in long-time conflict with hospitals because they react negatively to being told that their complaints are "in your mind." As a result, they are forced to struggle all the more forcefully "to prove how sick I am."

If the psychoneurotic soldier's complaints are continuously denied because "there are no organic findings," he—true to the nature of his neurotic character—finds himself in more intensive conflict with the army with which he is already having a problem. He becomes locked in an almost never-ending campaign to get across his illness. Under these circumstances, treatment becomes an extremely difficult matter.

The military psychiatric social worker does not deny the soldier's gripes and complaints, despite the lack of physical findings. After all, it is known that, scientifically, emotional tension can be the causative factor in physical manifestations—that of psychosomatic disorders. The military psychiatric social worker accepts the complaints with the soldier for what they are. At the same time, he represents and asserts the army's standards and needs with the soldier-patient, with understanding of his difficulties. In short, his approach is to accept both the problem of the soldier and the army's needs, with the goal of helping the soldier progress to the point where he can be and is willing to be of service within his liabilities and assets.

This help may enable him to gain his self-initiative and work through some of the repetitive fears that have been precipitated as a result of actual combat. His illness may be incapacitating, but unless it is totally so, he usually has enough assets to perform some military duty. To facilitate this, the military psychiatric social worker has "at his fingertips" the varied and many occupations in military service and can, through military mental hygiene, help the soldier evolve to the point where he participates in the considerations that lead to the recommendation of a potential assignment.

In the counseling process, the military psychiatric social

worker has and uses his understanding of the emotional conflicts and experiences in military service that have led to the breakdown of the individual soldier. Through his awareness of the patient's attitudes, feelings, and resentments, as well as assets, and through his knowledge of the army and its regulations, as well as his ability in administering the particular service of the mental-hygiene unit, help is offered to the psychoneurotic soldier. In effect, one of the most important aspects of the military psychiatric social worker's job is that of helping the soldier to become identified again with the group—with the unit, as it were. To facilitate this process and to provide for an expression of the soldier's problems, as well as for a synthesis of his conflicts, activity in groups is offered. One of the most important elements in the military psychiatric social worker's job is to work particularly with those soldiers who manifest severe difficulty in one degree or another in adjusting to group activities and group interaction.

The soldier-patient's reaction within the groups is used by the military psychiatric social worker in treatment. Generally, there are three types of situation that evolve. First, there is the patient whose symptoms are mild and whose personality organization is directed toward duty. He tends to find the group a positive experience. The military psychiatric social worker has minimum contact with him, and group therapy bears the burden of treatment.

Secondly, there is the type of patient who is finding it difficult to relate to the group because of his emotional conflicts and disturbances, but who shows some potentialities for progress. In these cases, the military psychiatric social worker sees the patient individually, while, simultaneously, the soldier continues to participate in the group. The individual treatment thus becomes geared to the difficulties the soldier is having in the group in terms of the multiple meanings of his behavior and its pertinence to his conflict with the army.

A third type of patient is the one who is so totally centered on his problems that he is unable to engage in any activity that requires his getting out of his shell. This man is not suitable for any group activity and is seen often and intensively by the military psychiatric social worker. He may

be some one who should be considered for discharge from the service. Or, if after a number of individual sessions, he shows some change in a positive direction, he may be returned to the group and seen individually, simultaneously with his activity in the group.

Potentially, the duty to which the soldier will be eventually reassigned should incorporate the basic elements that will tend to motivate as well as to sustain him. In cases in which the psychoneurotic manifestations are rather pronounced, but in which the soldier still shows interest in returning to duty, one of the major services to him becomes channelized into recommending assignment within his capabilities. Often, a well-conceived change in assignment may go a long way in reorienting the attitudes of the soldier toward return to duty. For example, the mild-mannered, quiet individual who broke down while serving in the military police, was found to have a pronounced fear of exercising authority. As an M. P., he felt that he could be of no further service to the army. In the treatment process, it was seen that the soldier had a natural interest and aptitude for auto mechanics. He could accept return to duty in such an assignment, as a result of his participation in working out such a plan.

The Rôle of the Military Group Therapist.—Group therapy is provided to achieve necessary clinical results. It attempts to meet individual needs through a group process. Military group therapy becomes part of a total process in helping the psychoneurotic soldier with his problems of adjustment to army life. The program is so organized as to meet the needs and problems of the soldier-patient, to enable him to regain sufficient confidence to return to duty.

The group itself is the basic structure of any army organization and it always serves the purpose of a specific mission. The group, as set up in the mental-hygiene unit, has as its primary purpose that of helping the soldier who has become ill to be sufficiently well to make use of his army skills and experiences.

This does not exclude treatment of personality factors that are fundamental to the individual's way of adjusting. It makes possible a differentiation between treatment *per se* and treatment of personality deviations, brought on

through army experience, that lend themselves to readjustment. In order to achieve this, the group therapist's orientation is always related to the limits and goals of the army. The soldier's emotional problem will thus become a factor in the process of his group's activities, as it relates to his problem in the army. This is accomplished through three types of grouping: group orientation, interest and activity groups, and discussion groups.

1. *Orientation.*—Each soldier who comes to the mental-hygiene unit participates in the orientation process. Overseas men are separated from the non-overseas men and are placed into small groups. This separation is made because of the obvious difference in personality strength of these soldiers. The groups meet from one to three sessions weekly, during which period any questions they may have about the mental-hygiene unit's program and set-up are answered. The purpose and function of this installation is also explained.

At the same time, the military group therapist,[1] who is a military psychiatric social worker trained in the use of group methods and treatment, begins to help the soldier-patients release some of their feeling concerning their further adjustment in the army and to prepare them for reassignment to the military psychiatric social worker for further treatment.

The orientation process enables the soldier to release some of his negative feeling and resistance to this new installation and prepares him to accept treatment. He learns very quickly that the program is set up to help him, and that

[1] A military group therapist must have the following qualifications:

1. He should have a thorough knowledge of psychodynamics, with appropriate educational background and training in a recognized school of social work and agency. This must include supervised field-work training, involving participation in continued-treatment relationships for a minimum of two years. See job specifications of the military psychiatric social worker (SSN #263) above.

2. He should have experience in group therapy under psychiatric supervision.

3. In addition to the above, in order to be qualified for this practice in the army, he must have a thorough knowledge of army organization and administration; of conditions under which army jobs must be performed, with emphasis on personality requirements and needs.

4. He must have a knowledge and understanding of the interrelationships between the other members of the clinical team—psychiatrist, psychiatric social worker, and psychologist.

5. He must have an understanding of the therapeutic objectives within the limits of army directive.

there is no need to "fight it." At the same time, it speeds up the treatment process in that resistance to treatment, to a large extent, does not have to be handled on an individual basis.

The orientation process also enables the therapist to single out those patients who appear very ill and who might be considered for discharge. It also singles out those soldiers who seem ready to go back to duty immediately. These soldiers are processed and taken care of immediately. Thus, the treatment time and the personnel are concentrated on the men who need it most—namely, the soldiers who are amenable to being helped toward a point of view where they can return to duty.

2. *Interest and Activity Groups.*—These groups are organized upon the assumption that almost every soldier received here for rehabilitation has acquired some useful skills and abilities during his army life of training and duty. The group begins treatment with an army-rooted common denominator. These individuals, for any one group-treatment program, are selected on the basis of jobs previously performed in the army. Thus the soldier is given an area of familiar experience with which to identify. The number of soldiers in the groups are kept relatively small, so that individual attention can be constantly given, thus avoiding the classroom effect. Such groups as auto mechanics, electricity, army administration, and clerical work exist, and it is around such interests that the soldier is able to work through his problems without the possible unproductive results involved in discussing unconscious or deep personality material and feeling, unrelated to the army.

These groups are small and informal; the soldier is encouraged to say what he pleases and what he thinks and to express freely his feelings on all matters that come to his mind. These feelings are expressed through actions and activities (such as, in an auto-mechanics' group, demonstration of the transmission, carburetor, and so on).

Emphasis is placed on group participation and interaction, encouraging the soldier to express himself and helping him regain his self-confidence. The soldier's ego strengths are emphasized and attempts are made to get him involved in some positive activity away from his personal problems. The

group activity does not, however, serve as an escapist or covering-up process. Each soldier is given ample opportunity to express himself, whether negatively, positively, or not able to participate, and through this group process he is brought to a point of readiness for return to duty.

Thus, an extremely depressed overseas soldier, who had broken down after combat and was exhibiting anxiety symptoms, was enabled to regain his self-confidence and ability to do a job well by being encouraged in an electrical group to manipulate electrical equipment. The understanding that the military group therapist had of this soldier and of his behavior pattern enabled him to examine some of the soldier's feelings and handle them, encouraging him at one point and facing him with reality at another point.

After a number of sessions, he was encouraged to lead the group in the discussion of an electrical object, which he did with some resistance. His acceptance of the group, however, and his success in presenting the subject served to help him regain confidence in himself and begin to find a place for himself in the army. He was returned to duty with the recommendation that he be given an assignment in which he could utilize his electrical knowledge and aptitude. Such procedures are not to be considered as occupational therapy *per se* because group therapy begins where occupational therapy ends.

3. *Discussion Groups.*—Discussion groups are organized for those soldiers who can adjust more easily to, or who prefer, verbal expression to actual activity. Such feelings as resentment toward treatment, effects of continuous hospitalization, feelings of being "pushed around," concern of the soldier as to what is going to happen to him, attitudes and behavior that indicate concern as to whether he is to be returned to duty or discharged, and, generally, fears, suspicion, resentment, and guilt expressed in various forms and manner, are discussed.

The group therapist helps to release these feelings, analyzes them, and relates them to the soldier's specific problems in adjusting to the army. This process grows out of the mutual participation between the soldier-patients and the group therapist. The therapist then helps to reorient them toward considering return to duty.

Involved in this is also development of interest and, in some instances, combining participation in discussion groups with activities. The group process thus involves activity catharsis, self-expression through activity and discussion, development of interest, and reorientation toward return to duty. The progress of one encourages another soldier to more positive effort. Thus, the personal interaction of the group is of primary therapeutic value. The men find others within the group who have similar problems and confusions, which reduces their own sense of guilt and feelings of inadequacy.

For example, the overseas soldier who had strong fears about returning to duty, with constant anxieties about being killed, was able to release considerable feeling about his battle experiences and secure a more realistic picture of himself within his present army setting. Through participation in a war-purpose group, he was able to reactivate his own convictions about his part in the war and was able to consider return to duty and a reassignment.

Another example is that of the soldier who had not been overseas. He developed conversion symptoms of lameness in his left leg. As a result of a close individual and group therapy process, he was able to release an extreme amount of hostility and feeling. Coupled with some understanding of his own particular problem, his marked limping changed enough for him to be returned to duty willingly.

The military group therapist must work closely with the military psychiatric social worker in assisting the psychiatrist to evaluate the soldier diagnostically and in his treatment. There are periodic conferences with the psychiatrist and the military psychiatric social worker in which the progress of the soldier is discussed and evaluated from the point of view of further treatment or disposition. If a soldier appears to be unfit, he can be changed to a different group or his reassignment recommended.

Where a soldier's problem, as manifested in the group, seriously interferes with the possibility of return to duty, he is at once referred back to the military psychiatric social worker, who will utilize the additional information and the experience of the soldier as a guide to his own further understanding and disposition of the case. Military group therapy

thus has diagnostic as well as educational and treatment values, in that it discloses those soldiers who are unable to relate to the group or groups and who need intensive counseling or psychiatric case-work treatment.

It is to be expected throughout that many conscious and unconscious negative impulses will operate in the soldier-patient selected for such group treatment. Such attitudes can more readily be dealt with when the group is rooted in a common army skill, interest, or problem. This gives the therapist a thread for the direction of his purpose. Again, where extremely negative attitudes tend to disrupt the group, this may be a diagnostic clue for the military psychiatric social worker and group therapist, indicative of a more severe maladjustment.

The soldier attends, on the average, three sessions per week, of one and a half hours per session, for a total of four and a half hours of group therapy per week.

One of the more interesting features of the program is the use of officer-patients and soldier-patients together in the same group process. Officers, as well as soldiers, are utilized to lead some discussions in which they are skilled. This serves as part of the therapeutic process in helping them regain their confidence in themselves and their sense of being related to army life.

At present, there are twelve groups functioning, with more contemplated. These groups are:

1. Auto mechanics
2. Electricity
3. Radio
4. Army administration
5. Army clerical
6. Noncom leadership
7. Army orientation
8. Current events
9. Military arts and crafts
10. Military plans and operations
11. Orientation to the mental-hygiene unit and the facility
12. Special problem groups, based on the soldier's difficulties in army adjustment.

The Treatment Process.—The case histories that follow are offered in digest to illustrate some of the salient features of the approach of the mental-hygiene unit to treatment of the

neuropsychiatric casualty within the limitations of army directive.

The individualization of the soldier and the awareness of gradual progress toward reorientation to return to duty become the keynotes of this process. It is of primary importance that the soldier be recognized as being "sick" at the starting point, so that the need for him to restate and overstate his symptoms may be reduced. It is also extremely important that he be reassured that he has been able to discharge the duty with which he has been charged, since many have the feeling that they have let their outfit down by being unable to continue.

In the discussion of the limitations that the soldier feels, there is a release of much of the negative feeling that he has piled up during the period of service, and a preparation for some consideration of the more positive aspects of capability becomes possible. The military setting in which he finds himself offers him the opportunity of meeting army living requirements on a level on which he can feel that he has the ability for satisfactory performance. As he finds this out, confidence returns progressively to the point at which he may be able to do duty on a par with his performance prior to the point at which the demands of the army overwhelmed his abilities.

Case 1.—A thirty-one-year-old first lieutenant in the Engineers was admitted to the mental-hygiene unit after seven and a half months of hospitalization. The symptoms were severe headache, visual distortion, "blackouts," uncontrollable tenseness when there were aircraft of any kind in the vicinity, nightmares, poor appetite, and incessant cigar smoking.

The lieutenant felt that he had improved when he arrived at the mental-hygiene unit, but was still uncontrollably tense near aircraft and had occasional headaches, as well as battle dreams during which he would awaken at the foot of his bed, where he had been accustomed to dig his fox hole. He felt very much "disgusted" with himself because of his prolonged period of unproductiveness, and indicated that he should either be discharged from the army or returned to duty without delay.

The need of the unit for a clear picture of his complete situation in order to discharge the responsibility that the army had delegated to it was accepted by the lieutenant as a necessary step toward one of the two decisions that he suggested could be made. Such a review of his background revealed a very conscientious individual who, after leaving school after high-school graduation because of economic necessity, developed a successful auto-repair establishment. He saved sufficient funds

to return to college after an interval of several years and completed a course in mechanical and electrical engineering. He was commissioned from R.O.T.C. and, under combat, earned the Legion of Merit as transportation officer in a combat engineer unit. He recalled his experiences of having been blown out of a fox hole by dive bombers and also having experienced extreme conditions of strafing under fatiguing conditions. There were long periods of incessant activity during which responsibility was great and rest was impossible.

During the course of the individual evaluation and discussion of his background and experiences, it was arranged with the lieutenant, who was very anxious to get into an activity where he was able to use his vast technical knowledge, training, and experience, to discuss such possibilities with the group-therapy department. In a short time, he had secured army ordnance manuals, and under the direction of the group therapist, had begun to develop an auto-mechanics and an electrical group with enlisted men of such inclinations.

The interviews continued concurrently, and the lieutenant, as discussion progressed, showed much less tension and did not press for a decision of "discharge or duty." He began to participate in his own evaluation to the point of rejecting the possibility of discharge and indicating the possible assignments that he felt able to meet responsibly. He took on more and more of an active rôle in the group program and activities as he became oriented toward return to duty.

This officer was returned to duty, and follow-up reports indicate that he was first given the assignment of instructor. He was rated "excellent" and subsequently was made transportation officer in a replacement center and then was placed in charge of a motor pool and made commanding officer of a motor-transport company. At the last follow-up report, he was still rated "excellent" and had been recommended for his captaincy.

This officer, whose background revealed a very responsible person who had been extremely productive, arrived at the mental-hygiene unit after seven and a half months of invalidism and unproductivity. In the initial states, in individual discussion with the military psychiatric social worker, he placed complete responsbility for decision in the hands of the army. It became most important to give him a share of this responsibility and to bring him to the point of participating in the final decision.

Through the medium of his technical training and interest in being active again, the military group therapist was brought into the situation. This gave him an opportunity to rekindle and reawaken the talents and capabilities that had been submerged through emphasis upon his illness. It also gave the mental-hygiene unit an opportunity to observe and to evaluate the officer in a more real situation than a purely clinical one. As progress was noted, return to duty

could be approached on a sound basis in which the officer and the mental-hygiene unit each assumed a proper share of the decision.

Case 2.—A thirty-one-year-old Army Transportation Corps man of average intelligence was admitted to the mental-hygiene unit after six months of hospitalization. He was hospitalized after a direct hit had sunk his ship during an amphibious operation (the third in which he had participated). His symptoms were severe pain in the back and stomach, coarse tremors of the hand, insomnia, and a startle reaction. After his gall bladder was removed, he recovered rapidly, and felt better except for persistent "heartburn" and headache which did not respond to medication.

A review of his civilian and military adjustment indicated that he had usually been a hard-working and conforming individual who, although he had had difficulty in finding work on occasion, showed a willingness to perform at any manual employment, even though unrelated to the plumbing trade for which he had been trained in a vocational high school. In the army, he had been classified as a longshoreman and had been rated "excellent." In discussion of his job, he said that he felt he might have had a more skilled classification, but showed some hesitancy about undertaking any more responsibility. At the point of initial evaluation of his capabilities, he felt that his physical condition was such that he would be unable to carry on the degree of physical activity required by either his army job or his plumbing occupation. In view of his mechanical inclination, he was referred to the group program, mechanical section.

In the group, it was noted that he showed interest and ability, but also that he displayed a tendency to attempt the heaviest of manual lifting. In interviews, he was given reassurance as to having done a good job in combat, but he revealed a great deal of concern over having been hauled out of the water when others of the crew had not been so fortunate. He felt this more keenly since he was not a swimmer. He was able to discuss the experience at length with the military psychiatric social worker. He found the activity of the mechanical group very absorbing, and indicated that while he felt he was not in the condition in which he was accustomed to be, he found that he was still able to do many things. In this, the attempt was made to minimize the goals he had set for himself.

The soldier's records had been lost as a result of enemy action, and he was referred to the psychologist for an evaluation of his intellectual capacities and aptitudes, after discussion of this step which was indicated as necessary in relation to definitive recommendations for return to duty. He was evaluated as of at least average intelligence and showed an aptitude for clerical as well as mechanical work.

As progress was noted, the soldier's symptoms diminished to the degree that though he still had mild "heartburn" after his breakfast, he felt that this would not interfere with his return to duty, which was what he now desired.

It was recommended that this soldier be returned to duty for assignment in relation to his mechanical and clerical aptitude, but that his physical condition did not warrant reassignment to the military occu-

pational specialty to which he had been assigned. Follow-up reports indicate that the soldier is doing "excellent" work in a clerical capacity in a port of embarkation.

In this case, some of the factors operating in the first case are equally evident. This soldier, however, has, in a measure, lost his most valuable asset—that of physical capability. This is evident in his attempts in the group to "test" himself by seeking to do the heaviest of manual jobs. It becomes a device almost to confirm the fear that he has of never being able to do the things of which he was once capable. It was important to relieve some of the pressure that he was placing on himself, and the awareness of this factor, as well as its remedy, was possible through the coördination of the military psychiatric social worker and the military group therapist, each of whom recognized his rôle in the treatment process.

The psychologist was brought into the case as progress indicated a readiness in the soldier to consider return to duty in a capacity commensurate with his present capabilities. His background and experience, as well as the need to replace the data lost when his ship was sunk, offered a basis on which to discuss the need for necessary psychometric evaluations. The results were incorporated in the recommendations for reassignment upon return to duty. They were specific and couched in army-validated criteria and in accordance with army procedure and directive.

Case 3.—A twenty-five-year-old infantryman of high average intelligence, was admitted to the mental-hygiene unit after five and a half months of hospitalization. He had been hospitalized after being in a combat zone for fifty-four days. The symptoms at the time of his hospitalization were severe anxiety, enuresis, tremulousness, insomnia, anorexia, and a marked startle reaction.

In interviews, the soldier was able to discuss his combat experiences at length, particularly his being so "scared" and "shaky" toward the end that he "couldn't even hold a gun." He felt unable to do combat duty again and seemed at a loss as to what he could do. He had taken a commercial course in high school, and after his father, to whom he had been very much attached, had died, he had become the breadwinner of the family, holding a job in the shipping and receiving department of a mill. In the group program, he began to participate in the clerical-administrative section and derived a good deal of satisfaction from this. An army clerical-aptitude test, administered by the psychologist, indicated superior ability, both in capacity and in potentiality.

The progress of the soldier was apparent in his increased verbalization

of the fact that he had done the best he could and was willing to continue in an army assignment that he could perform. As he was accepted on this basis, he reported a diminution of battle dreams, and an increased interest in the structure of army administration and supply. He enjoyed the physical program and attributed his returned appetite to this factor.

Return to duty was discussed with him on the basis of the interest that he had developed in supply and the process whereby such assignment might be effected. The soldier also had been certified for the military specialty of squad leader, and since he felt some confidence in his ability to carry this assignment through trial within the company, it was recommended as an alternative assignment.

In the initial stages of treatment, this soldier was largely preoccupied with his battle experiences and almost consumed with what he felt was his failure as a combat soldier. After a period of dwelling on this theme without further pressure from the demands of army standards beyond his immediate capacities, he was given an opportunity of relating to the army in a manner in which he felt capable. The interrelationship of the military psychiatric social worker, the military group therapist, and the psychologist again is illustrated as the focus sharpens in the direction of return to duty. The rôle of the company as a further agency through which the soldier was given the opportunity of feeling that he could still perform as a squad leader, is also illustrated.

Throughout the discussion of this process, the basis on which the program rests is evident. This is embodied in the technical training and experience of the psychiatrist, who directs and supervises the program. In treating the neuropsychiatric casualty by this method, a depth of understanding of the underlying forces of personality that are in operation becomes the barometer of the course of treatment. An appraisal of the personality strengths and weaknesses of the individual is a constant requirement, as progress or lack of progress is evidenced. If the symptoms of the soldier become aggravated within this setting, then it becomes significantly apparent that therapy of a more individual technique is required and that the soldier is too ill to profit from this program. This, likewise, indicates that he is too ill to return to duty, because treatment over a prolonged period is not available in the army.

The Rôle of the Psychologist.—The psychologist, as a member of the mental-hygiene unit's clinical team, fits into the

study of the soldier's total personality through the several psychometric services he may be called upon to give both to the diagnostic and to the therapeutic aspects of the unit's over-all responsibility. His function is twofold: first, the more traditional rôle of determining, where necessary, the soldier's intellectual capacities, special abilities, interests, and skills through the use of standard validated tests; second, that of making certain psychometric tests of personality study by means of special testing procedures—such as the Rorschach, the Bender Gestalt, and the Harrower-Errickson techniques—which have been found helpful to the psychiatrist, often as a time-saver. Further aid has been the use of group-test procedures where it is of paramount importance that information be available very soon after the soldier's placement here.

All psychological data are obtained only in relation to specific questions and problems as they pertain to the individual case and thus are used in a functional manner, so as to make for the maximum efficiency of the mental-hygiene unit's psychological service.

The Rôle of the Red Cross Psychiatric Social Worker.—It has been possible to develop a definition of the job function of the Red Cross psychiatric social worker in relation to the staff and program of the mental-hygiene unit, as based on its varied experiences since it was first organized in January, 1942.[1]

An analysis of army and of American Red Cross regulations had indicated that there were several areas of function in which this Red Cross worker has an essential contribution to make to the mental-hygiene unit's program of treatment, especially in the case of soldiers suffering from personality disturbance. It is necessary that as thorough a knowledge and understanding as possible of the nature and history of the soldier's problems of army and civilian adjustment be available. In its function of liaison with the community, the Red Cross is able to provide the army with civilian social-history data gathered by its home service. This may be very valuable in certain cases in which the treatment and

[1] See "The Services of the Military Mental Hygiene Unit," by Major Harry L. Freedman, M.C. *American Journal of Psychiatry*, Vol. 100, pp. 34–40, July, 1943.

disposition of cases by the mental-hygiene unit may be expedited by necessary and reliable information relative to the soldier's background, which has a bearing on the problem presented by his maladjustment in the army.

In order to secure such information from the lay community, it is essential that the Red Cross psychiatric social worker be highly skilled in order to be able to understand the nature of the soldier's illness as it is described to her by the military psychiatric social workers in the mental-hygiene unit, and to be able also to translate the professional concepts given her into a language that will be understandable to the layman in home service. Only by such delicate interpretation can the information be related to the soldier's difficulty and the soldier's best interests be served in the army as well as protected in the community. An understanding of the resources of Red Cross Home Service is a corollary for this service.

Another function of the Red Cross is in giving a direct service on extra-military matters to the soldier who is under the mental-hygiene unit's supervision. Through its liaison with the local chapter of the Red Cross, the worker can give help to the soldier's family and reassure him to the extent that the home service is able to free him of additional anxiety, which may be contributory to or aggravating his condition. This function must be carried out in close relationship with the mental-hygiene unit, since the emotional impact of familial complications are severely reactive in soldiers with personality illnesses. It is necessary that the psychiatrist supervise such activities, and it requires professional understanding of the soldier's problem as well as a delineation of function on the part of the Red Cross worker.

A third function of the Red Cross worker possible through relationship to the military mental-hygiene unit is the utilization of the knowledge of the soldier's problem and course of treatment in assisting the soldier's return to civilian life, if the disposition of the case is discharge from the army. Although army responsibility ceases with discharge, the Red Cross worker attached to the mental-hygiene unit as a member of its staff has available the knowledge of his illness necessary to help the man relate to civilian agencies and problems through selection and reference to local Red Cross chapters

or other public and private social agencies that may help him in adjusting to the community.

Experience has demonstrated that the qualifications required of the Red Cross psychiatric social worker, functioning as one of the members of the staff of the mental-hygiene unit, are as follows:

1. The Red Cross social worker must be thoroughly familiar with all of the services provided to the army and to the soldier as they are defined by army and Red Cross regulations.

2. The Red Cross psychiatric social worker must be a trained professional case-worker with some experience in a psychiatric agency in which she has gained a general understanding of emotional illness.

3. The Red Cross psychiatric social worker must be able to work in close coöperation with the military psychiatric case-workers, under the supervision of the director of the mental-hygiene unit.

4. The Red Cross psychiatric social worker must have an appreciation of the mental-hygiene unit and of her own area of responsibility; *e.g.* she must understand that the army, through the director of the unit, is ultimately charged with the responsibility for treatment given to all patients, and that Red Cross services given to the soldier direct (loans, help with allotments, home problems, discharge, and so on) or to the unit directly (Red Cross reports, inquiries, and so on) are the primary service that she can offer.

5. The Red Cross psychiatric social worker must be especially creative in the use of her services in order to help the soldier make the most use of her help, and must be able to differentiate her services from those of the mental-hygiene unit, which are different, but yet closely related to the soldier's total problem. Thus in giving to the soldier any one of the various Red Cross services, the worker must be capable of distinguishing between those problems which are primarily of military concern and those which are caused chiefly by an extra-army (home, financial, discharge) problem. This functional differentiation is in keeping with Red Cross and army directives, and must be strictly adhered to.

6. From a general psychiatric social worker's point of view, this American Red Cross service becomes particularly helpful to the mental-hygiene unit in working with soldiers because it facilitates for the soldier a clearer understanding of his problem in the army. The functional differences between the mental-hygiene unit and the Red Cross handling of a soldier's problem helps both the unit and the Red Cross to avoid duplications, and prevent confusion on the part of the soldier, and also helps the unit to solve the military aspects of the soldier's problem which the soldier often has identified with nonmilitary causes.

Return to Duty and Follow-Up.—In recognition of the fact that the psychoneurotic, even in the best circumstances, will have some problems in meeting the realities of army life, it has been necessary to give special consideration to his problems. The importance of this has been recognized in

War Department Circular 100,[1] March 9, 1944, which charges the unit commander with the responsibility of giving the individual an assignment appropriate to his mental or physical capacity. In all cases of men returned to duty, the mental-hygiene unit discharges this responsibility as far as the medical officer's part is concerned. The unit makes a brief evaluation of the soldier, covering diagnosis, intellectual capacity, aptitudes, skills, and recommendations for training and assignment. Whatever is applicable in these areas is transmitted through channels with each soldier, individually, to his new unit.

Under War Department directive, a physical profile serial number or code is given each case, which further expedites efficient classification and reclassification. Routine or periodic psychiatric check-up is of necessity recommended on all cases returned to duty. The above procedures are seen to be necessary in order to give the unit commander, or whosoever may have contact with the soldier later, a basis for obtaining the most efficient service from him. Our reports will also assist any one who may be called upon to handle the soldier's problem to help him more efficiently and expeditiously.

Civilian and military experience has shown that the psychoneurotic can make a very useful contribution if given adequate understanding and supervision. The method of following up cases handled by this mental-hygiene unit has been to request a periodic report, covering general physical and mental status and efficiency with assignment at two- to four-week intervals. At least three such questionnaires or prepared forms are sent out to the next station on each case, as soon as the soldier returns to duty. The date on which reply is requested is on each form. A descriptive letter with the mental-hygiene unit's findings and recommendations accompanies these three or more forms. It is very similar to the formal 201 letter and makes it possible to obtain some idea as to how the soldier is progressing in his new assignment. This provides an additional means of evaluating the unit's work. Another form is submitted that requests information regarding transfer of the soldier from his last station,

[1] As amended by War Department Circular 217, Section II, dated June 1, 1944.

so that subsequent follow-up requests can be routed correctly. Progress notes thus requested cover the first two- to three-months period after the soldier is back on duty.

The coöperation received from the various line organizations is most commendable, considering that soldiers may be returned to duty anywhere in the United States. The initial recommendation of the mental-hygiene unit on all neuropsychiatric casualties contains the request that this soldier be kept within the continental limits of the United States as a noncombatant. This is the next step in readjustment and does not mean that he may not eventually be sent anywhere in the world as a noncombatant at least. This the soldier returning to duty understands.

First return reports are generally received four to six weeks after the soldier is back on duty, since most of our cases are overseas men and generally have some furlough time due them. This they receive from the reception station after arrival there from the mental-hygiene unit. The first month of duty is very important, probably the most important, and is also very difficult for these men, and may determine whether or not they will be able to sustain good adjustments. Everything that the soldier returning to duty will have to face is more or less discussed with him before leaving the mental-hygiene unit. This is both an educational and a good mental-hygiene measure and serves to allay the anxiety states to which psychoneurotics are so prone.

For the period of January through June, progress reports have been received as of July 1, 1944, on 36.3 per cent of all the soldiers returned to duty during this period. Many fewer replies have been received for the soldiers returned to duty during April, May, and June, for the reasons above given. Most of these reports, covering the second half of the study, should be at hand between August and September.

Of all the progress reports (36.3 per cent) received, 69.8 per cent are on soldiers who were returned to duty during the first three months of the study, and 30.2 per cent of all the reports received are on men returned to duty during the last three months of the study.

A breakdown of the follow-up reports on those doing satisfactorily or better gives the following results:

	Per cent symptom free	*Per cent with symptoms*
Efficiency satisfactory	26.8	17.3
Efficiency very satisfactory and very good	12.9	4.3
Excellent and superior efficiency	25.8	12.9
Total	65.5	34.5

Thus, 65.5 per cent of those whose adjustment was reported as satisfactory, very satisfactory, good, very good, excellent, superior, were symptom free, and 88 per cent were adjusting to the service.

Of the 69.8 per cent reports above referred to covering the first three months, at least 89 per cent of the statements of evaluation by the soldiers' commanding officers indicated that they were performing their military duties in a manner rated from "satisfactory" to "superior." It is significant that in the qualitative statements by their commanding officers relative to this group who were able to continue to render service, 65.5 per cent were symptom free at the time the follow-up report was made. It is clear that while symptoms may abate or be reactivated, both the soldier and those responsible for his efficiency are aware of the fact that this does not preclude the recognition of ability to perform a job. It is felt that the ego strength derived from successfully performing an assignment and meeting reality demands is of sufficient continuing therapeutic value to compensate for periodic mild recurrence of symptoms. In this respect the same dynamic factors that hold true in psychoneuroses in general apparently prevail in the military environmental setting. These results validate the army policy of continuing psychoneurotics in service other than a combat theater.

Of the 30.2 per cent of the reports above referred to, covering the second half of the study, at least 85 per cent indicated that the soldiers were making a satisfactory to excellent adjustment.

Thus of the total on whom progress reports were received, as of July 1, 1944, 88 per cent were making a satisfactory to excellent adjustment.

About twice as many reports were received on overseas cases as on C.L.U.S. cases (soldiers who had not been out

of the continental limits of the United States), and the unsatisfactory ratings received were equally divided.

In about 70 per cent of all the cases, the mental-hygiene unit's recommendation was followed or a related vocational assignment was given. In 20 per cent, the assignment was not indicated, and in 10 per cent had not yet been made.

Analysis of Case Load.—The following is a percentage analysis of the mental-hygiene unit's case material. The data available lend themselves to a very comprehensive analysis. These statistics cover the soldiers who were treated between January 1, 1944, and June 30, 1944, and actually disposed of either by return to duty or discharge from the army.

Of the total number of soldier-patients treated in the mental-hygiene unit, 58 per cent were overseas soldiers and 42 per cent domestic or C.L.U.S. soldiers.

TABLE I.—DISPOSITION OF SOLDIER-PATIENTS BY TYPE AND MONTH

	Per cent discharged from the army	*Per cent returned to duty*	*Per cent of those discharged from the army*		*Per cent of those returned to duty*	
			C.L.U.S.*	Overseas	C.L.U.S.	Overseas
January	42.2	57.8	52.7	47.3	19.0	81.0
February	33.3	66.7	41.8	59.2	13.7	86.3
March	25.0	75.0	56.6	43.4	33.3	66.7
April	30.6	69.4	60.7	39.3	63.5	36.5
May	36.9	73.1	60.6	39.4	48.7	51.3
June	27.7	72.3	48.8	51.2	35.2	64.8

Per cent of total group discharged 29.5
Per cent of C.L.U.S. discharged.. 37.5
Per cent of overseas discharged... 24.0

Per cent of total group returned to duty 70.5
Per cent of C.L.U.S. returned to duty 62.7
Per cent of overseas returned to duty 76.0

* Soldiers who have not been out of the continental limits of the United States.

Table I shows that of all soldiers, 70.5 per cent, or seven out of ten, were returned to duty and 29.5 per cent were discharged. Broken down into C.L.U.S. and overseas soldiers, it shows that of C.L.U.S. soldiers, 62.7 per cent, or 2 out of 3, were returned to duty and 37.3 per cent discharged. The figures on overseas soldiers indicate that approximately three out of every four are being returned to duty, that the overseas psychiatric casualty has a better prognosis than the C.L.U.S. case.

TABLE II.—TIME IN SERVICE PRIOR TO HOSPITALIZATION OF SOLDIER-PATIENTS

	Per cent of discharged cases		*Per cent of cases returned to duty*	
Time in service	C.L.U.S.	Overseas	C.L.U.S.	Overseas
Up to six months	42.1	1.2	13.4	1.0
Six months to 1 year	19.7	22.1	20.6	13.9
1 to 2 years	30.3	50.0	48.1	55.3
Over 2 years	7.9	26.7	18.9	29.8
	100.0	100.0	100.0	100.0

Table II shows that of the C.L.U.S. soldiers discharged, the largest percentage, 42.1 per cent, had had less than six months service; whereas 50.0 per cent of the overseas men discharged had seen from one to two years of service.

Of the C.L.U.S. soldiers returned to duty, 48.1 per cent had seen from one to two years of service, and of the overseas men, 55.3 per cent had seen the same amount of service. This would seem to indicate that the prognosis is poor for neuropsychiatric casualties with short periods of service, particularly those who have not been able to finish basic training.

TABLE III.—INTELLIGENCE LEVELS OF SOLDIER-PATIENTS

	Per cent of discharged cases			*Per cent of cases returned to duty*		
	Total	C.L.U.S.	Overseas	Total	C.L.U.S.	Overseas
Superior—Group I	7.6	12.8	0.0	2.4	4.1	1.3
High average—Group II	28.8	41.0	11.1	22.3	28.0	18.8
Average—Group III	24.2	25.7	22.2	29.8	23.6	32.2
Dull—Group IV	36.4	20.5	59.3	35.5	32.4	38.3
Border-line—Group V	3.0	0.0	7.4	10.0	11.9	9.4
	100.0	100.0	100.0	100.0	100.0	100.0

TABLE IV.—EDUCATION OF SOLDIER-PATIENTS

	Per cent of discharged cases		*Per cent of cases returned to duty*	
	C.L.U.S.	Overseas	C.L.U.S.	Overseas
College level	17.1	4.4	16.4	5.7
High-school level	55.3	51.5	46.1	64.1
Grammar-school level	23.7	44.1	37.5	30.2
No schooling	3.9	00.0	00.0	00.0
	100.0	100.0	100.0	100.0

TABLE V.—GENERAL TYPES OF ASSIGNMENTS RECOMMENDED BY MENTAL-HYGIENE UNIT

	Per cent of cases
Clerical	34.4
Basic	20.1
Truck driver	13.4
Auto mechanics	9.3
Cook	3.2
Utility repairman	2.1
Weapons' instructor	2.3
Other skilled jobs	15.2
	100.0

TABLE VI.—DIAGNOSIS UPON DISPOSITION OF SOLDIER-PATIENTS

	Per cent of discharged cases		*Per cent of cases returned to duty*	
Psychoneurosis:	C.L.U.S.	Overseas	C.L.U.S.	Overseas
Anxiety state	34.1	47.1	29.7	51.1
Conversion hysteria	11.9	8.8	30.5	9.8
Neurasthenia	5.3	2.9	4.7	1.8
Hypochondriasis	1.3	0.0	14.7	2.3
Mixed type	43.5	33.8	12.5	29.7
Constitutional psychopathic state	1.3	0.0	6.3	3.3
Post-concussion syndrome	1.3	2.9	0.8	1.5
Epilepsy	0.0	1.6	0.0	0.0
Psychosis	1.3	2.9	0.0	0.5
Simple adult maladjustment	0.0	0.0	0.8	0.0
	100.0	100.0	100.0	100.0

Hospitalization Time.—A comparison of the length of time spent in the mental-hygiene unit with that spent in prior hospitalization showed that of the total period of hospitalization, the time spent in the mental-hygiene unit averaged 21.4 per cent for the discharged men and 23.1 per cent for the men returned to duty, and the time spent in prior hospitalization averaged 78.6 per cent for the former and 76.9 per cent for the latter group.

Age Distribution.—The average age of the C.L.U.S. soldiers who have been discharged from the army is twenty-seven; of the C.L.U.S. soldiers who have been returned to duty, twenty-five. The average age of the overseas soldier discharged from the army is twenty-seven; of the overseas soldier who has been returned to duty, twenty-six.

CONCLUSIONS

The process described in this paper is presented as a generic and applied method for the evaluation and treatment of the military neuropsychiatric casualty. Inherent in the process described are the continuously changing attitudes and behavior of the soldier throughout this period of convalescence, in a line company therapeutically controlled by the mental-hygiene unit. Through the integrated approach with the company, the military group-therapy program, the individual therapeutic interviews, and contacts, there is adequate opportunity for a very careful appraisal of the soldier's personality strengths and weaknesses, as well as of his intellectual capabilities and limitations. The soldier has demonstrated the degree of responsibility he is capable of assuming through his participation in the program of the mental-hygiene unit. The entire process has been related to the requirements the soldier will be expected to meet in a duty status. Based on the mental-hygiene unit's observations and evaluations, a specific assignment by army specification serial number for which the soldier is best qualified, with formal army training-center retraining and reclassification or both, may be recommended. Toward this the soldier has been motivated and he is aware of the limitations that are involved in such decision as defined by army directives indicated above.

The change has been from "bathrobe to barracks," in the mental-hygiene-unit setting above described. In this army setting, new to the soldier who may have been long hospitalized, all of the skills of the mental-hygiene unit are brought to bear toward motivating and returning him to duty. Each member of the clinical team fulfills, in coördination with the others, his special skills and function.

The military psychiatric social worker, under the supervision and direction of the psychiatrist, is the psychiatrist's chief psychiatric aid and carries the major individual and group treatment program and its coördination with the company. By virtue of the military psychiatric social worker's training and experience in dealing with problems arising from maladjustment to duty, due to complications of an emotional nature, he is able to render the most effective possible treatment within the army setting.

This clinical team functions efficiently and effectively while observing the principles of acceptable professional practice in the field of mental hygiene. As evident throughout this presentation, the handling of the psychoneurotic is a responsibility of medical practice and military psychiatry. This holds true for the "prescriptions" on job assignment and recommendations under which the soldier returns to duty or is discharged. These soldiers have emotional problems which have resulted from a conflict between duty assignment and their individual emotional tolerance for frustration. Because of this, return to duty and the nature of assignment can be responsibly arrived at only on the basis of a total psychiatric evaluation of the soldier's problem.

The validity of this unit's work during its present mission at this installation has been positively established through follow-up reports, which show that at least 88 per cent of these neuropsychiatric casualties who have returned to duty have made readjustments that range from satisfactory to superior. As previously noted, this should not be construed to mean that these men who were able to continue to render military service were symptom free. The possibility that their symptoms would continue to be more or less in evidence is clear. However, the ego strength derived from successfully performing an assignment and meeting reality demands is thought to be of sufficient continuing therapeutic value to compensate for periodic mild recurrence of symptoms. In this respect, the same factors that hold true in the psychoneuroses in general would prevail, and the army policy of continuing psychoneurotics in service, but not in a combat theater, is validated. It is seen as being of the utmost importance that the unit commander follow the medical officer's recommendation in detail.[1]

The principles of a basic mental-hygiene program, as presented, can function most effectively where parallel trial-of-duty training opportunities are available. In the absence of these, skeleton-shop equipment can be utilized, since it is the emotional content of a soldier's activity itself that is the deciding factor in a decision for return to duty. As has been described, this is the therapeutic factor in group therapy.

[1] See "Mental-Hygiene First Aid for Precombat Casualties," by Major Harry L. Freedman, M.C. MENTAL HYGIENE, Vol. 28, pp. 186–213, April, 1944.

With the rapidly increasing need and importance of an adequate mental-hygiene program for the neuropsychiatric casualty, these methods can be geared to further use, providing the necessary personnel is available for training.

The unit's team has been accepted as a new principle in the application of professional skills in army psychiatry. The principle of the mental-hygiene unit has here again demonstrated a very vital and special usefulness in dealing with the problems of the neuropsychiatric casualty of military life. It has been shown that just as the Civil War gave impetus to the growth of neurology, and World War I to the rôles of psychiatry, World War II is bringing about a recognition of the usefulness of the mental-hygiene clinical team as a most effective combination of psychiatric, psychiatric social work, group therapy, and psychological skills toward solving the pressing problem of neuropsychiatric casualties.[1]

[1] See "Mental Hygiene Clinics in Military Installations," by Major Harry L. Freedman, M.C. in the *Manual of Military Neuropsychiatry* (Philadelphia: W. B. Saunders Company, 1944) Chapter 39. See also *One Hundred Years of American Psychiatry* (New York: Columbia University Press, 1944) pp. 431–32.

BOOK REVIEWS

SOLDIER TO CIVILIAN: PROBLEMS OF READJUSTMENT. By George K. Pratt, M.D. New York: McGraw-Hill Book Company, 1944. 233 p.

As Dr. Stevenson states in the Foreword to this book, the widespread problems of readjustment and rehabilitation of returning service men will demand the highest degree of social statesmanship for their solution. Since mental hygiene must inevitably play a significant part in this work, there has been great need for a book that points the way in which the basic principles of mental health can be applied in this challenging new field. Dr. Pratt's long record of service on the staff of The National Committee for Mental Hygiene, his experience as rehabilitation consultant after the last war, and his recent work as psychiatric examiner at the New Haven Induction Center, all qualify him in an outstanding way to speak with authority on this subject.

Dr. Pratt's main purpose in this book is to create an atmosphere of understanding in which the reaclimation of returned service men can proceed in the most constructive manner. The book is written on the popular level, and is intended to serve as a handbook for families, friends, and prospective employers of returning service men. It is written in the same clear, forceful, lucid style that distinguishes the author's other works. The present volume also makes full use of the case-example approach.

The opening chapters are concerned with the soldier's pre-military psychological equipment, and with the strains of varying intensity that military life makes on his capacities for adjustment. Following this is a brief review of military programs for morale maintenance, including the work of several mental-hygiene clinics set up by the armed forces.

In a chapter entitled *Soldiers with Psychiatric Disabilities,* after devoting considerable space to the traditional stigma and fear that are attached to psychiatric terms, Dr. Pratt presents a rough classification of the more common psychiatric disorders that may occur in discharged soldiers. The discussions of specific mental and emotional disorders is necessarily brief, but it is regrettable that the explanation of psychoneurosis, condensed to only seven pages, remains somewhat overtechnical.

The last three chapters give examples of the more common symptoms indicative both of minor and of major maladjustment during the

first few weeks at home, in connection with getting reacquainted with the family and with returning to work. A section dealing with the types of problem that arise upon reëmployment was contributed by a leading industrial physician and his consulting psychiatrist.

Dr. Pratt's emphasis throughout the book is on the need for understanding rather than for rigid techniques. As he states, our aim should be to help the disabled ex-service man to the fullest extent of his need, but we must be sure our aid is of the kind that helps him to help himself. This book also serves to prepare for the earliest possible reference to the proper agencies of personality problems and adjustment difficulties of the more severe type which require competent psychiatric assistance.

The appendix to this excellent and timely guide gives a reprint of the material on "Community Services for Veterans" prepared by the newly created National Committee on Service to Veterans, under the auspices of the National Social Work Council.

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Psychiatry and the War. Edited by Frank J. Sladen, M.D. Springfield, Illinois: Charles C. Thomas, 1943. 505 p.

This volume, presenting the addresses and discussions at a conference on psychiatry held at the University of Michigan in October, 1942, contains much material of interest and value, but though the title suggests that one might expect an emphasis, at least, on military psychiatry and the personality disorders of war, these subjects receive scant attention. Few of the pages deal directly with the description, the pathogenesis, or the treatment of psychiatric conditions arising in battle. This is true not only of those sections of the book subtitled *The Philosophy of Psychiatry, Research in Psychiatry,* and *Psychiatry in the Training, Experience, and Education of the Individual,* but also in the sections nominally devoted to psychiatry and the war. The title could, therefore, justifiably be called a misnomer.

There are, however, many articles that merit attention. As is perhaps inevitable in the detailed reporting of a conference, this useful material is padded by, and occasionally all but buried in, repetitious paragraphs in which the discussants pay respect to each other and to the formalities. Though this may have been pleasant to hear, it is of little interest warmed up again in print for the reader.

The range of subjects treated is extremely wide. *The Future of Medical Research, Courtship and Marriage, Sociology and Criminology, Psychosomatic Research,* and *Psychiatry in Industry* are a few chapters that suggest the ground covered. In general there

is a prevailing tendency to stress the broader aspects of psychiatry, its relations to social, national, and even international problems. This is to be commended not only for what the study of the person may contribute to understanding of the group, but also because so much that disturbs the healthy functioning of the human being comes at cultural levels from his surroundings.

Many of the articles deserve attention. The treatment of psychosomatic research by Alexander is clear and in general convincing, though the reviewer cannot agree that all disorders dependent on autonomic innervation should be so sharply distinguished from the conversion manifestations of the voluntarily innervated mechanisms. Hysterical vomiting is too often and too obviously symbolic to be excluded by such a verbal cleavage. There is, by the way, much to be said for Cameron's condemnation, in another chapter, of the term *psychosomatic* as implying the very dualistic delusion that psychiatry is striving at last to outgrow.

Woods, in *Courtship and Marriage,* effectively and attractively brings out the broader aspects of sexuality and succeeds in integrating rather than contrasting them with direct genital activity. The article on sociology and criminology, by Healy, and that on propaganda, by Kennedy, are particularly stimulating and sound.

In his presentation of the subject of Symposium I, Meyer offers the best and most concise formulation of his much discussed and widely valued psychobiologic point of view that the reviewer has seen. In reading these nineteen pages the beginner in psychiatry can probably achieve a firm and enlightening grasp of this enormously important concept, which, in the reviewer's opinion, has almost entirely eluded expression in the few textbooks written by Dr. Meyer's pupils explicitly for the purpose of conveying it.

Though some of the matter in this volume is overgeneralized or spent in verbal amenities suggestive of the after-dinner speaker, it contains enough genuinely worth-while articles to recommend it.

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Foster Home Care for Mental Patients. By Hester B. Crutcher. New York: The Commonwealth Fund, 1944. 199 p.

Family care—to employ the shorter title usual in this country—was undertaken in Massachusetts in 1885. Other states lagged behind enormously. The most populous of them, New York, only in 1933 essayed to place patients in homes other than their own at a price set and paid by the state. A resolute commissioner found the money and an ingenious superintendent led the way. The social workers

did much of the work in establishing the system and by far the largest part of the supervision. In no small measure the project was well handled because of the skilful supervision of Miss Crutcher, Director of Social Work in the New York State Department of Mental Hygiene. She is in peculiarly favorable position to write an excellent book on the subject, and she has done so.

The volume starts with a shrewd explanation as to who should be placed out and why, and of the favorable responses to placement. The argument of the first chapter is so well knit and conclusive that it might be reprinted and widely distributed to stimulate interest; but every later chapter strengthens the presentation.

The mechanics of administration are very clearly presented. Costs are always important, so they are analyzed in Chapter II. One learns what sorts of patient were first placed out, and what extensions the plan has undergone. The experiences of New York are quoted most, but those of other communities, particularly Massachusetts, Maryland, and Ontario, are drawn on freely for illumination. We are told that all have been eager for extension of the system wherever it has been tried.

The approach to the community is set forth. It is to be deliberate, explanatory rather than hortatory, enlisting the interest of physicians, social workers, church members, and officers of local organizations. Misconceptions are broken down all through the book, in connection with other material that shows what one's informed attitude will be. Care is taken to discriminate between two goals—comfortable care and therapeutic stimulation. Extremely apt case material is cited. Unplanned improvement in many cases is described. The personal qualities of caretakers are discussed.

When the book was written, eight states had done something of consequence in this field. About 3,400 patients were under family care from mental hospitals and schools for defectives, much the larger number coming from the hospitals. In addition, two states had each one patient out. Two other states had legislation, but no money to effectuate it. It may be added that Indiana once had a patient in family care at the expense of relatives and under the supervision of a hospital superintendent who knew her well.

The author reviews the two systems of distribution of these patients —the colony system and the district system—in Europe and here, presenting arguments pro and con. She sees little virtue in the effort to develop a colony in this country. Still, we may venture to hope. Perhaps Quebec will be the favorable region for a colony.

The question of how many patients shall be placed in one house is discussed cautiously. New York has put as many as fifteen in one establishment, but ordinarily sets a limit of six; to those who

believe in greater individualization, six seems quite high enough. Maryland never places over two in one house, but California allows six and Rhode Island eight.

The discussion covers the attitudes, responsibility, and experiences of the patient, the hospital, the relatives, the foster family, and the community. Questions of authority are carefully explained. There is a surprising amount of detail, so distributed that it is not burdensome to the reader; even the desire of many patients to buy medicine is mentioned. When material is repeated, it is given fresh value suitable to the new context. A set of forms is given and adequately explained. They include the instruction book issued in New York to those who operate such foster homes.

The format will look familiar to those who know the fine series of brochures issued in our field by the Commonwealth Fund. Miss Crutcher's study does credit to herself and to her publisher.

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INSTITUTIONS SERVING CHILDREN. By Howard W. Hopkirk. New York: Russell Sage Foundation, 1944. 244 p.

In no other field of equal importance is there such a dearth of accessible and understandable material as in that of the institutional care of children. Consequently, teachers and students of child welfare and workers in children's institutions owe a debt of gratitude to Mr. Hopkirk for bringing together and organizing the results of a long and varied experience in institutional work.

The value of his contribution in this book is increased by his penetrating observations and his suggested standards of institutional care. He has attempted to place the institutional care of children in a proper perspective with reference to other forms of foster care. He recognizes that, in attempting to give this broad perspective, he must sacrifice intensive treatment of various phases of the subject. While he confines his attention for the most part to institutions for dependent and neglected children, his description of the problems makes it apparent that there is a very shadowy and indistinct line between these and institutions for delinquent children.

The book is divided into five parts. Part I, *Place of the Institution*, is given over to a discussion of the need for institutions, their development, their relationship to foster homes, and the needs of the child in terms of community resources for meeting them.

Part II, *The Staff*, gives numbers and qualifications needed, staff training, and living and working conditions of the staff. We found

this section most helpful, and we believe that other institutional administrators will find it so. The book deals with staff problems in a frank, courageous way. They have long needed such treatment. The author's intimate experience with the problems of recruiting, training, and keeping staff are shown clearly in his treatment of this subject.

Part III is given over to a discussion of the structure: organization and plan. In Part IV, *Care of the Child*, the author discusses institutional case-work, the physical needs of the child, and its education and training. One important chapter under this heading has to do with the costs of institutional care. Institutional administrators will be gratified that the author emphasizes the variables that complicate comparison of costs, and rejects the widely used, but erroneous measurement of costs on a per-capita basis. He points out that per-capita costs vary so—depending upon services furnished, age of children, length of stay, condition of plant, and so on—that a per-capita-cost measurement has little value.

In Part V, Mr. Hopkirk deals with the evaluation of an institution in terms of causes of obsolescence, standards commonly used in appraisals, objectives, and the like. His long experience in making surveys of children's institutions makes this part of his book particularly helpful for boards and executives who are concerned about the extent to which they are meeting community needs.

One of the problems that is receiving a great deal of attention in the institutional care of children is the extent to which shelters should be used for dependent and neglected children. Mr. Hopkirk describes the inadquate provisions that are made for temporary care in most cities. The discussion as to which children need institutional care gives helpful suggestions for developing an integrated community program for foster care. We were particularly impressed by his emphasis upon small groups in cottages; his recognition of the need to avoid overloading the staff; the dangers of impersonal treatment when this occurs; and the need for younger, better-trained, better-paid, healthier workers in institutions. As he rightly points out, this is basic in any foster-care program dealing with children deprived of wholesome home influences.

The reviewer feels that Mr. Hopkirk has rendered a real service to the large number of workers in the institutional field, and that this book, with its sane, practical treatment of the problems of institutional care, should be a part of every child-welfare worker's library. It should result in more intelligent and more effective care of the 250,000 children in the United States who "go to bed each night in the dormitories of child-care institutions."

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THE DIFFICULT CHILD AND THE PROBLEM OF DISCIPLINE. By C. W. Valentine. Cleveland, Ohio: The Sherwood Press, 1941. 104 p.

The author, professor of education at the University of Birmingham, England, addresses this book "to students of the psychology of childhood and especially of difficult children, and to parents and teachers, who are trying to get from the study of psychology some light on the problems of discipline and of the difficult child." In particular he deals "with some ideas which are receiving widespread attention and which masquerade as sound psychology, but which seem to be both untrue and harmful."

He explains what he means by the term "difficult" child: "Not only the extreme cases of difficulty, the so-called 'problem' children who are in complete revolt against authority at home and at school, or who play truant or lie or steal, but in particular that much more frequent type which is 'difficult' at home or at school, resentful of discipline, or excessively aggressive; the type of child who in the last century would have been called simply the 'naughty' or 'spoilt' child. We shall also refer to the child who is diffident and needs encouragement rather than restraint, and the child who becomes too emotionally dependent."

Part I of the book deals with psychology and the difficult child, and gives a rather sketchy critical review of past and current ideas and controversies about the importance of early childhood experiences and the significance of sex in infancy; the term "problem"—applied to children or parents; the problem of heredity vs. environment; the claim that character is determined in the early years and that nursery-school education is most important for that reason. The author's discussion of the work of child-guidance clinics and related studies leads him to the following suggestions for the parents of a difficult child: "(1) honestly to examine themselves and see that their own treatment of the child is not too severe or too indulgent; (2) to provide other society and other control besides their own, even additional to that given by a day-school; and (3) to be willing in very serious cases if necessary to place the child in an entirely different environment."

In the second part of the book, the problem of discipline is discussed with some use of the terminology introduced by Sigmund Freud and Alfred Adler. According to the author's own viewpoint, most problem behavior is due to inadequate, inconsistent, and especially too lax parental discipline.

There is something rather unfortunate about this book and its purpose of guiding students of psychology and education. The author discusses with more resentment than objective criticism the influence, upon education in general, of psychoanalytic trends, ideas

derived from the study of child development, and the practice and research of nursery schools and child-guidance clinics. We agree with him that we would like to see the profession of psychologists protected against unqualified elements, and would like to see the public safe from them. We also feel that some modern theories of psychological development derived from limited experience with the mentally unbalanced may lack scientific proof, and that the case-study method used more and more in the study of human beings has at times led to unjustified generalizations. However, all these new approaches toward a deeper insight into the behavior of men are a promising part of the study of modern psychology, and to dwell on all the negative aspects of these psychological trends and to cite disconnected questionable statements as proof of fallacies is hardly sound teaching.

The author has tried to disprove some of these statements, such as the assumption that infantile fears, compulsions, outbursts of temper or cruelty are forerunners of later mental deviations, by conducting surveys among his friends and students with regard to their children's nervous symptoms during childhood, which he claims existed at one time or another without leading to later more severe difficulties. This focusing upon symptoms and traits rather than upon the dynamics of behavior and the larger patterns in which symptoms are imbedded makes the discussion rather sterile.

We miss almost entirely a real understanding of the newer teaching of the social-emotional development of the child and of his relationship to members of his family and other persons important in his life. What parents or teachers do to their children seems to be in Dr. Valentine's eyes mainly wise or foolish measures and manipulations leading to control or failing to do so. Where education fails in spite of good parental discipline, he feels that the child's overstrong impulses or inborn defects are to blame. Thus the author seems to have overlooked the tremendous importance, for progress in psychology and education, of the broadening interest in behavior and its underlying motivations, the part feelings and emotions play in social life, and how they affect mental development, interests, and energies.

ANNI WEISS FRANKL.

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GUIDING THE NORMAL CHILD. By Agatha H. Bowley. New York: The Philosophical Library, 1943. 168 p.

This book, while apparently written with British readers in mind, is published in this country, and so must be reviewed from the point of view of American readers.

Dr. D. R. MacCalman, of the University of Aberdeen, Scotland, has written a foreword for the book. He refers to the author's experience in nursery-school training, as a lecturer in a teachers' training college, and as organizer and director "of the very successful Dundee (Scotland) Child Guidance Clinic."

Dr. Bowley states that the purpose of the book is to bring to the attention of parents and teachers the emotional development of the normal child from birth through adolescence, as an equally important and interdependent corollary of his physical and intellectual growth. She seems to consider this a new idea to the readers for whom the book is intended.

She states that "most British psychologists tend to follow the Dynamic, rather than the Behavioristic school of psychology, which is still popular in America and is regarded by most British psychologists as too narrow and too limited in its concept of human behavior." Quite a number of American psychologists might take exception to this statement.

Brief as the book is, it might have been even briefer, simply as a correlation and guide to the long and comprehensive bibliography, which is included at the end of each, but one, of the chapters. Of the one hundred and sixty-eight pages of the book, six and a half pages are devoted to bibliographies of works pertaining to this and allied subjects. The list runs the gamut of published works in this field, dating from 1920 to the 1940's.

On the other hand, the book could have been considerably expanded and amplified as the author's narrative account of the difficulties encountered in the normal development of the child. The case studies, of which there are a considerable number, could advantageously have been discussed more fully, and more adequately related to the particular condition that they illustrate. Their brevity, and the lack of analyzed application to the situation under discussion, do not bring out their greatest value. Only a reader already well informed in psychology could realize their significance.

Dr. Bowley repeatedly states that she hopes to whet the reader's appetite for the references in the bibliography. It is a question whether this result is achieved. Rather, the effect of cramming narrative, case histories, and bibliography into so few pages is one of confusion. This reviewer wonders whether the average parent or teacher reader would not be blocked in her interest toward enlightenment instead of being stimulated toward further seeking

Although the book is written for readers presumably unversed in psychological terminology, the vocabulary is sufficiently technical so that the author has appended a page and a half of glossary. Perhaps the British lay reader would turn to the glossary to find the meaning of unfamiliar words; it seems unlikely that American readers would.

There is no doubt but that Dr. Bowley has enough material, experience in her field, and knowledge of allied literature to have expanded this work into a really comprehensive and informative volume. It seems unfortunate that she has so condensed a smattering of medical, educational, and psychoanalytic theory as to give very little meaning to any of them.

In the last chapter, *Children and the War,* Dr. Bowley obviously depends on her first-hand experience and conveys her message in vital, simple, lay terms. Her narrative style is pleasant and easy. There is a minimum of literature pertaining to this current phase of child experience to which the author can refer. This is the sole chapter not followed by a bibliography. The result is a much meatier contribution—all Dr. Bowley's own. META L. DOUGLAS.

Philadelphia.

THE FREEDOM TO BE FREE. By James Marshall. New York: John Day Company, 1943. 277 p.

In his recent book, *Our Age of Unreason,* Franz Alexander develops the important idea that whenever a person faces a frustration that is beyond his power to overcome, "he tends to revert to the gratifications which are normal to earlier stages. Maturity shows itself in learning to find real solutions to one's problems." How democracy depends upon this better practice is aptly stressed and illustrated in these chapters (one of which, *Competitive Society,* first appeared in MENTAL HYGIENE) by the former president of New York City's Board of Education. Says Marshall:

> "The fundamental human patterns, which underlie our lives from nursery to the inner councils of industry and politics and form that composite, plaid pattern which we know of as society, include at least these tendencies: (1) A tendency to seek dominion over others in order to quiet anxieties of insufficiency. (2) A tendency to preserve dominion over others—to maintain a paternalistic relationship. (3) A tendency to attempt to gain equality in order to obtain freedom from paternalism—or to attempt to complete the fantasy of an all-powerful father-figure. (4) A tendency to confuse equality with identity—to find anxiety in differences, to feel cheated if identical treatment is not extended. (5) A tendency to attempt to compel identity in others because of an implied threat when it is necessary to measure ourselves, our achievements or ambitions, against others."

And all the time great needs exist, too—"a need to find security in acceptance by others, in the development of our capacities and the sharing with others of experiences and the fruits of those capacities. A need to find security in self-reliance and collaboration rather than in a search for power or reward from those in power—security in brotherhood rather than in competition. These, together with

problems set for us by the physical world, are the real objects to which the political sciences must address themselves. The others are fantasies or symptoms. The maladjustments of political institutions, of economic practices, of social relationships, of educational curricula, are the fevers and the rashes of society. Their adjustment depends not upon patching them up, not upon fiddling with their machinery as much as upon understanding the maladjustments of the human beings behind them and guiding people to healthy maturity."

Therefore, as against "aggression and subservience, paternalism and domination as the way of life," we must find ways "to help people free themselves from those anxieties which produce paternalism, which deny equality, which demand identical treatment and behavior, which drive people to competition and aggression and to seek dominion over others. It is the choice between the approach of politics and the approach of ethics and science. Only when politics serves ethical ends and satisfies the mature needs of man, can political institutions assure men the freedom to be free."

In referring to Germany, Mr. Marshall is happily free from a common misconception in books and articles dealing with the conduct of that nation as a problem in mental hygiene. He does not analyze a single sick-minded German and present the result as the picture of an entire people. He puts his hope mainly on those Germans who are themselves more ethically mature than the Nazi misleaders. So he wants a peace settlement that will help Germany work out her own way to maturity and that must, therefore, avoid sowing the seeds of another outbreak some twenty years later. Moreover, he is acutely aware how many Americans, far from being qualified to bring democracy to other lands, have every need to enlighten and improve their own sad practices right here at home.

Mr. Marshall sees the war itself as one expression of a world-wide revolution, a rebellion against the inferiorities bred in people by economic insecurity, by the dominations exercised by superior wealth and other kinds of power. But he is also aware that even if economic security were more broadly distributed than to-day, many people would still "lust for power to compensate for real or imagined inadequacies." Therefore, while he pleads for a social reconstruction that will provide much more protection against explosive frustrations, he insists upon the paramount importance of an education that will better prepare people to measure up to the high demands of ethical maturity.

For example, in his discussion of Liberty, Equality, Fraternity, he wants young people to learn early not to confuse equality with identity. Instead, he would have them accept the fact that people, beginning with one's own brothers, sisters, classmates, differ in

physical and mental capacity, in backgrounds, in needs to be satisfied; that we must share with others and act with others without fear of thereby losing out; and that the shared experiences of equals in this sense bring a more genuine satisfaction than the outbursts of the sullen, the jealous, or the power-lusting.

In every chapter, parents, teachers, citizens, will find suggestions like these worth pondering and practicing. One criticism must be voiced: The author seems to have been misled by John Dewey into making Immanuel Kant the philosopher responsible for the authoritarianism of Prussian officials. While it is true that these persons took the formal conception of the categorical imperative and stuffed it with the idea of the state as absolute authority, nevertheless, let it be remembered, nobody did more than Kant himself to protest against treating people as mere means to the ends of others and to urge respect for the individual as an end in himself. His essay, *Toward Lasting Peace,* a plea for a world-federation of republics, was a bigger job for a German to write in the eighteenth century than is many a plan for peace proposed to-day. Differing with Kant in metaphysics need not involve denying him the respect to which he is entitled.

HENRY NEUMANN.

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THE EXPRESSION OF PERSONALITY; EXPERIMENTAL DEPTH PSYCHOLOGY. By Werner Wolff. New York: Harper and Brothers, 1943. 334 p.

It is a pleasure to call the attention of readers of MENTAL HYGIENE to this book. It deserves to be rated as a classic for the skill of its experimental attack on the dynamics of personality. Wolff's initial work, beginning in 1925, pioneered in the application of the Gestalt point of view. While American psychologists were fumbling with ratings and aimlessly computing correlations, Wolff had a theory and a method for the study of personality that yielded clear answers to many problems. His volume is a "must" book for all psychologists who are seriously interested in experimental studies of personality and its underlying dynamics.

Instead of centering attention on single elements or traits of personality, Gestalt psychology is interested in the structure of personality, the interplay of forces exhibited by the organism as a whole in specific situations. Thus, instead of rating dominance on a ten-point scale, Gestalt psychology would point out that dominance may represent a compensatory mechanism; that it may appear in an individual's relations to his subordinates, but not in his relations to his peers; that an individual may dominate others, but be unable to make decisions for himself; that ratings of dominance

by different judges may have different meanings. Instead of studying a single personality trait and investigating its distribution and correlates in a population, Gestalt theory would prefer to study a single personality and to understand its dynamics in a series of situations.

Despite the shortcomings of its theory, the measurement of single traits had great merit in the eyes of American psychologists because it led directly to experiments that could be repeated and to quantitative findings that could be verified. In the early 1920's, the Gestalt approach to the study of personality seemed to lead only to more psychoanalysis. It is Wolff's contribution to have conceived a well-controlled and appropriate experimental method that yields quantitative findings. Among personality studies, Wolff's earlier work has been accorded the unique distinction by Huntley at Harvard of systematic repetition and successful verification.

Wolff's point of attack is the external manifestation of the personality in facial expression, voice, gait, handwriting, gestures, rhythmic behavior, and so on. Photographs, motion pictures, and sound recordings were made. A typical series of experiments ran as follows: A group of subjects read aloud a single sentence which was electrically recorded for later reproduction. Observers characterized the personality of these voices. Substantial agreement was found among these characterizations. Next, ten judges summarized these characterizations into a single word or phrase, and these summary characterizations were verified by matching with the voices, using another group of judges. A third group of judges then matched these summary characterizations with such of the subjects as they knew well. All judges made twice as many correct matchings as chance would indicate; one judge was correct ten out of eleven times. This demonstrates that personality, as judged from a voice sample, agrees with personality as judged by personal acquaintance and by observation of overt behavior.

In his experiments Wolff discovered that observers rarely recognized their own voices even when their attention was called to the fact that their own voices were included in a series, a finding later verified by Huntley. Now comes a critical question: Do self-characterizations of a voice sample given in the absence of recognition of one's own voice agree with the characterizations of others? They do. Moreover—and this is one of the most exciting of Wolff's findings—these self-characterizations made in the absence of recognition tend to be more emotional, more penetrating, and more complete.

A brief summary of only a tiny portion of Wolff's work is, of course, most unsatisfactory. One must read the volume to appreciate

its meticulous care for detail and scientific control, the great variety, flexibility, and appropriateness of its experimental method, and the richness of the implications of its findings for a deeper understanding of personality.

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DEAFNESS AND THE DEAF IN THE UNITED STATES. By Harry Best. New York: The Macmillan Company, 1943. 675 p.

This book by Dr. Harry Best excellently presents the sociological aspects of deafness in America. The author is an authority on the subject; he has spent a third of a century in the education of the deaf, in social work, and in the teaching of sociology.

The book reports factual material amassed by the author in palpably diligent and painstaking research. It is divided into two parts. In the first part, the author confines himself rigidly to unbiased reporting of facts. His personal views on deafness comprise the second portion. Here, the author links his personal experiences in this field with general trends reported in the first section by statistical tabulations and references to the literature.

The book begins with an anatomical description of the organ of hearing. This preludes a discussion of the causes of deafness. Unfortunately the nonmedical reader will find this technical description rather meaningless. On the other hand, the medical reader will be apt to chafe under inaccuracies in it, arising principally because the author has confused the cochlear apparatus and the vestibular organs. He writes, for example, of the labyrinth as a structure of hearing rather than as the organ of equilibration. In the main, however, the generally excellent character of the remainder of the book makes such errata of negligible importance in the sum of the whole.

The discussion of the causes of deafness, with its implications for the prevention of this affliction, is extremely interesting and revealing. The statement that scarlet fever and meningitis account for one-fourth of all deafness presents an interesting and stimulating challenge to the medical profession. The author emphasizes the increasing effectiveness of new methods in the treatment of acute infectious diseases. Although he does not state it, it would appear that with the use of penicillin and the sulfa drugs, one can anticipate a decrease in deafness from these causes alone.

The author advises reporting all cases of deafness to health departments as one means for the prevention of deafness. It is, however, difficult to comprehend how reporting deafness to such sources will result in anything more than interesting and perhaps valuable statistics. Almost invariably deafness would be reported too late for any known therapy to be effective.

As a reference volume combining important information on the deaf population in America, the book is justly destined to be a standard text. The number of deaf persons in the United States, together with their distribution by geography, by sex, by age, by race and nativity, and by age at the onset of deafness, all furnish valuable data; and because of the simple, friendly style of the author, the book makes definitely interesting reading.

Figures quoted by the author must, of necessity, be brought up to date from time to time. Noteworthy changes, no doubt, will derive from the addition of many cases incident to military service.

Economically, deaf persons in America have fared very well, according to the author. Statistics on this point are very surprising. The high incidence of employment among them has been attributed variously to preparation for industry in vocational schools, to a more enlightened public, and to the strong motivation of the deaf to be self-supporting. Further, the author shows that deaf people have a very low accident rate, occupationally, in industry, and in the operation of motor vehicles. This he attributes to the high degree of caution deaf persons must always exercise because of the elimination of the auditory sense. The author expresses hope that wide knowledge of this fact will permit access to certain jobs for which employers are still reluctant to hire individuals with auditory handicaps.

The chapters on the education of the deaf are extremely illuminating. It is especially comforting to learn that the problems of the education of the deaf have been so effectively met. The author indicates many parts of the country in which considerable improvement might be made in this type of instruction, but he also makes plain that by and large present needs do not compare with the problems that existed a half-century ago.

Specific problems in the education of the deaf are also discussed. The fact that communication is impaired slows the general educational process and delays its inception. The author advocates a plan for very early instruction, particularly during the pre-school period. These concepts are well known to educators of the handicapped; larger cities provide instruction at early age periods. In small rural areas the problem of the deaf child of nursery-school age still offers realistic obstacles.

Methods of instruction of the deaf are discussed at some length. The author pleads for tolerance of the deaf in the use of the sign language. He refers to this means of communication as the mother tongue of the deaf. He intimates that the time and effort expended in the instruction of the deaf in lip reading and the use of the voice might be more expediently channeled to vocational training. Although the author also shows diagrams of the manual alphabet and the method of teaching the deaf how to use the voice and lips,

he fortuitously assists in keeping the sign language a secret means of communication among the deaf. It is to be hoped that future editions of the book will include a chapter on the use of signs, thus making this language available to every one for ready communication with the deaf.

Although the author mentions a few problems of the handicapped, he does not offer a sufficiently clear picture of the inner mental reactions of the deaf individual. He believes that the deaf person generally does not require sympathy, that he is a proud individual who wants no special favors. He seeks mainly to be treated as an intellectual equal, to receive equal treatment in civil service, industry, and trade.

The deaf desire no economic favors or subsidies. They are proud that there is no need for any special agencies for their care. They seek eagerly an adequate opportunity for good industrial and vocational training. (It is to be understood that all time schedules concerning ages for beginning and ending school do not apply to the deaf because of many factors.) This attitude perhaps represents the average deaf individual who has made a satisfactory adjustment. The reviewer would be interested in data demonstrating the ratio of deaf persons to hearing persons in mental hospitals and prisons as compared to those in the general population. It would be of specific interest to learn something about the attitude of the deaf to the hearing, and some of the emotional struggles the deaf undergo in adjusting to a world geared to the spoken voice. In this connection the author does bring out a fact that is of interest regarding the movies. The deaf get less satisfaction from sound pictures than from silent films.

The problem of marriage of the deaf is treated by the author, although some questions are left unanswered. It is well known that the deaf are more comfortable with each other than with hearing people. In as much as girls meet boys in schools for the deaf, it is only natural that they should marry. There can be no question as to the eugenic factors in people with congenital deafness who have children. The reviewer would like to suggest that even in acquired deafness there is some problem regarding the rearing of children. Though few data are available, the environment of a home with deaf parents and an upbringing by such parents can hardly be considered wholly normal for a wholly normal child. Such problems are very delicate and are perhaps wisely avoided by the author.

The book is in sum a very worth-while volume, one that should be owned by all interested in this and related fields. One feels after reading the book that although the education of the deaf is very expensive, it should be managed freely and willingly by the state

because of the high rewards in thus converting potential burdens into useful, effective members of society. With modern educational methods the deaf can move among their fellow men and hold their heads high in the knowledge that they have much to contribute to our economy and our civilization.

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I WANTED TO SEE. By Borghild Dahl. New York: The Macmillan Company, 1944. 210 p.

An interesting literary development in the last few years, accelerated just now by the problem of rehabilitating those disabled by war injuries, has been the publication of a considerable number of biographical and autobiographical accounts of the lives of persons handicapped by various physical disorders and defects. Quite a number of these stories, written by relatives, other intimates, or the handicapped person himself, have appeared as articles in popular magazines. Many brief accounts of the lives and remarkable achievements of handicapped or aged persons have also recently been published in the news or feature stories of daily papers. In addition, a series of such stories are now available in book form.

The accumulation of this literature is valuable for several reasons. It helps handicapped persons and their relatives to appreciate that their problem is not exceptional, but one that has had to be faced and wrestled with by many other people. They are stimulated and encouraged in their efforts by the knowledge of just how others similarly handicapped have overcome their limitations and have, in spite of serious obstacles, been able to achieve varied, satisfying, and, in some instances, phenomenally successful lives.

These case stories also help professional people and students to understand such social problems from the point of view of the inside feelings and experiences of the handicapped person himself. Another service that they often render is that of making employers and the general public more optimistic about the capacities and potential contributions of handicapped or partially disabled persons. Such accounts should also stimulate interest and concern for more adequate medical, health, and social programs, which will prevent a high percentage of such disorders. It is sublimely stupid to concentrate on developing elaborate facilities for the treatment, education, and adjustment of handicapped children and adults, if effective programs for the prevention of these disorders are neglected. It is socially more valuable to prevent such disabilities than to adjust people to them after they have occurred.

In her book, *I Wanted to See,* Borghild Dahl tells the story of

her lifelong struggle to overcome the many difficulties that had to be confronted every hour of the day by one handicapped from earliest childhood by almost total loss of sight. Her problem was not only to succeed in spite of a minimum ability to see, but to outwit the terrifying threat of total blindness. Every achievement in her life entailed far more time, thought, planning and preparation, and exertion and persistence than is required of the average, normal person.

In spite of added financial and family responsibilities, the total lack of special educational facilities for visually handicapped children, and the necessity for several serious optical operations, she succeeded in obtaining a postgraduate education, and was popular and successful as a teacher in high schools and colleges and as a public lecturer. As a "distinguished student in sociology," she was awarded a year's study and travel in Norway by the American Scandinavian Foundation.

The source of her courage, ambition, and achievements appears to have been the attitudes and methods used by her mother in her early childhood training.

> "My mother counted herself in a kind of partnership with me while I was learning to adjust myself to the strange world into which I was born. . . . So it was as though this handicap of mine was not peculiar to me alone. When my mother was trying to teach me to dress myself . . . she always spoke as though we were both doing it. After I had finished, she taught me to run my fingers up and down the buttons to make sure that they were all in place."

Her mother patiently taught her how to manage all the normal activities of life.

> "All these every one else might have taken for granted that I could have learned just as any other child did, but my mother knew better and she taught me so quietly that no one, not even I at the time, realized what she was doing for me."

She taught the child to depend on herself, to care for herself, to find ingenious ways which helped her to participate in the normal activities and to carry her full share of work and other responsibilities in the home. She required of her the same high standards of performance she demanded of her other, normal children.

> "'You must do better than that,' my mother would tell me, taking me by the hand and pointing out the places I had missed. 'We who are not able to see as well as others must take more pains with our work. When we show how well we can get along, no one will remember that we have trouble with our eyes.'"

Her mother felt that it was "not kind to let her grow up without teaching her everything other children can do."

> "If my mother ever had any misgivings about my climbing, she did not let me know; for she included the other children whenever she pointed out any particular danger we might encounter in our play."

Although her blind eye was ugly to look at, at home "I had never been made to feel that my eyes affected my appearance in any way." Later, when she became aware of this æsthetic handicap, and the reactions of others to it, it was a constant source of sorrow to her. It was one of her happiest experiences when the eye was removed and she was fitted with a glass eye, which contributed tremendously to the attractiveness of her appearance and to her ease and pleasure in social relations.

This book, *I Wanted To See,* should be of interest and value to all those concerned with the care and education of visually handicapped children or adults and to others interested in the personality development and experiences of handicapped and partially disabled people.

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NEW GOALS FOR OLD AGE. Edited by George Lawton. New York: Columbia University Press, 1943. 210 p.

This century may aptly be called the century of the aged, for instead of their remaining a devalued group, interest in and knowledge of the aged is advancing rapidly. From a physiological, psychiatric, psychological, and social point of view, the aged individual is being scientifically studied. Many reasons are advanced for our previous lack of interest: until recently there have been relatively few in the population; as a group they are not pleasant to study; they are not important from an economic standpoint; and the subtle, unconscious fear of growing old ourselves may have its influence.

In the lectures that make up the book under review, psychiatrists psychologists, physicians, social workers, therapists, a sociologist, a librarian, and an anonymous woman of seventy-five years draw on their knowledge and experience to provide understanding for the individual over sixty.

These specialists emphasize the fact that there is much that is not yet known about this process of aging and aged people, but a review of the material presented indicates that the gap between what is known about older persons and what is used effectively in living with them and caring for them is wide. Although these writers have drawn knowledge and experience from such different fields, their agreement on the requirements of old people in the way of care and treatment is complete.

As Lawrence K. Frank, Vice President of the Josiah Macy, Jr. Foundation, points out in his paper, *The Changing Social Scene,* recent social-economic industrial changes demand of older people increased readjustment at a period of life when the individual is, generally speaking, less capable of making such change. For the

individual this means that his early patterns of life become incompatible with the changing social picture. Our pattern of society also lags behind. This necessary reorganization of an individual's life needs planning and the individual needs help in attaining it.

Before discussing the methods by which people may be helped to have a satisfying and happy old age, we must understand what aging is and what place it occupies in our span of living. The following quotation, from the paper, *Adjustment Over the Life Span,* by Dr. Lawson G. Lowrey, explains this:

> "The continuance of the life processes is complicated at all times by a growth-limiting tendency, a tendency we call senescence or old age. In any individual who lives long enough there is quite likely to come about, for a variety of reasons, some disintegration which will interfere with the smooth continuation of middle life. There are certain episodic waves in the pre-senile period which seem to me to be all important with reference to what the psychology of the older person will be.
>
> "For the individual, at any given moment or point, is the product of all that has gone before; a product, not a simple sum, of the series of environmental factors and stimuli to which he has been exposed and to which he has had to react. It is remarkable that, being exposed to these, he in turn reduces them to their social components . . . .
>
> "The point to remember is that the aging process is continuous and that it carries over from one period to another all that has gone before."

Aging is a natural process and one about which we need to change many of our concepts and increase our knowledge. As Dr. Nolan Lewis points out in his paper, *Applying Mental Hygiene Principles to Problems of the Aging,* " 'age' is an extremely elastic term which, in physiological concepts, can rarely be used in its chronological sense, as what is understood by 'age' in terms of structure-function may overtake a man in his earlier years or may manifest itself in irregular retardations and dysfunctions of special sets of organs, according to the results of predisposition, previous diseases, and the stress and wear and tear to which the body has been subjected in its journey through life . . . .

"We must take into consideration many different kinds of ages: mental, moral, physiological, and chronological."

With these concepts accepted as basic, the capacities of old people are stated and their utilization is suggested in the following papers: *The Older Person in the World of To-day—In the Family,* by Ollie A. Randall; *Physical Changes in Old Age and Their Effects upon Mental Attitudes,* by Lewellys F. Barker; *Work Therapy, Interests, and Activities,* by Edward Hochhauser; *Toward a Science of Bibliotherapy,* by Alice I. Bryan; *Occupational Therapy,* by Marguerite Emery; *The Creative Urge in Older People,* by Edward T. Hall; *Mental Diseases of the Aged,* by Samuel W. Hartwell; *Old Age at the Crossroads—Patterns of Living: In an Institution,* by Helen Hardy Brunot; *Old Age at the Crossroads—Patterns of Living:*

In the Community, by Ruth Hill; *Old Age First Person Singular,* by George Lawton; *How It Feels to Be Seventy-five and a Woman.*

For the benefit of the individual himself and of society, this reservoir of resources of older people should be used fully. All specialists agree that activity—both mental and physical, if possible—is essential for living. Continuation of work for pay, with diminished responsibility and release from pressure, but with opportunity for the use of judgment and creative ability, or when this is not feasible, occupational therapy through the development of new work interests and hobbies, may provide the means for such activity.

With this opportunity for activity must come also better understanding of the process of aging by the old person himself and a revision on the part of the community and of the families of the aged of their habits of thought about the aged. Miss Ollie Randall, Assistant Director of the Special Services Division of the Community Service Society of New York, says, " We may not be able to alter our definition of what a family is, but we can change our ideas of what a natural living arrangement for members of a family is if the individuals who compose it are to be happy and self-sufficient persons in the community." Miss Randall illustrates this idea by means of cases, and gives the reasons behind this need for a change in our thinking. Miss Helen Brunot, Director of the Bureau for the Aged of the Welfare Council of New York City, and Miss Ruth Hill, Associate Director of Public Assistance, in charge of Old Age Assistance, New York City Department of Welfare, indicate in their papers how plans for the aged may be made outside their own families.

This collection provides good instructional material for the use of all people who are growing old and for their families and workers. It will help to bring about a better understanding of the problems of the aged. I am sorry that more attention was not given to proper nutrition in relation to physical health and consequently to mental health, since the generation we have been discussing has missed being taught good dietary principles, although a great advance has been made in research and knowledge in this field.

More stimulating even than the knowledge that these papers show are the signs of further research and experimentation. Exact knowledge of the process of aging, study of the occupations in which the abilities of the aged may be most productive, and research into the measurements of the capacity of the individual aged person are indicated as fields needing further explanation.

This volume is an excellent beginning in the collection of material for the use of all interested in the aged.

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NOTES AND COMMENTS

Compiled by

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BILL ESTABLISHING A NATIONAL NEUROPSYCHIATRIC INSTITUTE PRESENTED TO CONGRESS

For several years The National Committee for Mental Hygiene has been on record in support of greater aid for psychiatric research, training, and service. Whenever it has been invited to testify before Congressional committees on related matters, it has discussed the deficiencies in this field. In its surveys of hospitals, its field consultation to communities, its guidance to beginners in psychiatry, in fellowships for advanced work, or queries from families who refused to accept our scientific limitations, the need for a program of proportions far beyond the range of private initiative has been repeatedly evidenced.

Several foundations—notably the Supreme Council 33° A. A. Scottish Rite Northern Masonic Jurisdiction—have done noble work in pushing forward the frontiers of knowledge, education, and service; and individual psychiatrists and others have given devotedly of their time, money, energy, and imagination to the same end. All this, however, has been so far short of an effort commensurate with the size and severity of the problem of mental illness that it is gratifying to see H.R. 2550 offered to Congress.

This bill, which was presented by Representative J. Percy Priest, of Tennessee, on March 9, is a direct outcome of Mr. Priest's years of close contact with the problems of people, the inevitable lot of the newspaper man. It is the product of careful study by Mr. Priest of legislative needs and professional opinion. As a result, we have a bill that can be given whole-hearted support. Every one interested in mental hygiene should read it. Its passage will be a milepost. It should be read critically and suggestions for its improvement sent to Mr. Priest or to The National Committee for Mental Hygiene as soon as possible in order that they may be received prior to committee action.

As will be seen, the bill establishes and defines a National Neuropsychiatric Institute under the United States Public Health Service.

It would be an institute in the broad sense of a function, not just a building. This institute would include a research center at Bethesda, Maryland, where it could enjoy the laboratory and other research facilities of that location. It would provide grants-in-aid to any university, hospital, laboratory, or other institution or agency, public or private, throughout the country, in which research can be carried on. The special importance of this decentralized provision for psychiatric research cannot be overemphasized, since in this field it is often so necessary to study the problem in the social setting in which it occurs.

The bill would provide, through grants, demonstrations, or otherwise, for the establishment of measures for the prevention and control of neuropsychiatric disorders, and would also provide funds for the training of personnel in this field, the lack of which has held up many developments.

Your Congressman will be glad to get your reaction to this bill, which follows:

"A BILL

"To provide for, foster, and aid in coördinating research relating to neuropsychiatric disorders; to provide for more effective methods of prevention, diagnosis, and treatment of such disorders; to establish the National Neuropsychiatric Institute; and for other purposes.

"*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,* That this Act may be cited as the 'National Neuropsychiatric Institute Act.'

"SEC. 2. For the purposes of conducting researches, investigations, experiments, and demonstrations relating to the cause, diagnosis, and treatment of neuropsychiatric disorders; assisting and fostering similar research activities by other agencies, public and private, and promoting the coördination of all such researches and activities and the useful application of their results; training personnel in matters relating to neuropsychiatric disorders; developing, and assisting States in the use of, the most effective methods of prevention, diagnosis, and treatment of neuropsychiatric disorders; there is hereby established in the United States Public Health Service (hereafter in this Act referred to as the 'Service') the National Neuropsychiatric Institute (hereafter in this Act referred to as the 'Institute').

"SEC. 3. In carrying out the purposes of this Act, the Surgeon General of the Service (hereafter in this Act referred to as the 'Surgeon General') is authorized through the Institute to—

"(a) conduct, assist, and foster researches, investigations, experiments, and demonstrations relating to the cause, prevention, and methods of diagnosis and treatment of neuropsychiatric disorders;

"(b) promote the coördination of researches conducted by the Institute, and similar researches conducted by other agencies, organizations, and individuals;

"(c) make available research facilities of the Service to appropriate public authorities, and to health officials and scientists engaged in special studies related to the purposes of this Act;

"(d) make grants-in-aid to universities, hospitals, laboratories, and other public or private institutions, and to individuals for such research projects as are recommended by the National Advisory Mental Health Council;

"(e) for purposes of study, admit and treat at the Institute, voluntary patients, whether or not otherwise eligible for such treatment by the Service, and patients of Saint Elizabeths Hospital transferred from the hospital pursuant to arrangements made between the Surgeon General and the Superintendent of the hospital with the approval of the Federal Security Administrator;

"(f) collect and make available through publications and other appropriate means, information as to, and the practical application of, research and other activities carried on pursuant to this Act;

"(g) secure from time to time, and for such periods as he deems advisable, the assistance and advice of persons from the United States or abroad, who are experts in the field of neuropsychiatric disorders;

"(h) establish and maintain, from funds appropriated or donated for the purpose, fellowships in the Institute with such stipends and allowances (including traveling and subsistence expenses) as he may deem necessary to procure the assistance of the most brilliant and promising research fellows from the United States and abroad;

"(i) (1) provide training and instruction in matters relating to the diagnosis, prevention, and treatment of neuropsychiatric disorders, (2) provide the necessary facilities where such training and instruction may be given to persons found by the Surgeon General to have proper qualifications, and designated by him therefor, and fix and pay such persons a per diem allowance during such training and instruction of not to exceed $10; and (3) provide such training and instruction through grants, upon recommendation of the National Advisory Mental Health Council, to public and other nonprofit institutions;

"(j) assist, through grants, demonstrations, and as otherwise provided in this Act, States, counties, health districts, and other political subdivisions of the States and nonprofit agencies in establishing and maintaining adequate measures for the prevention, treatment, and control of neuropsychiatric disorders, including training and instruction of personnel in subjects related to neuropsychiatry, and the provision of necessary facilities for such training and instruction; and

"(k) adopt, upon recommendation of the National Advisory Mental Health Council, such additional means as he deems necessary or appropriate to carry out the purposes of this Act.

"SEC. 4. (a) There is hereby created the National Advisory Mental Health Council, to consist of the Surgeon General, ex officio, who shall be chairman, and six members to be appointed without regard to the civil-service laws by the Surgeon General with the approval of the Federal Security Administrator (hereafter in this Act referred to as the 'Administrator'). The six appointed members shall be selected from leading medical or scientific authorities who are outstanding in the study, diagnosis, or treatment of neuropsychiatric disorders. Each appointed member shall hold office for a term of three years, except

that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and except that the first terms of the original appointed members shall expire, as designated by the Surgeon General at the time of appointment, two at the end of one year, two at the end of two years, and two at the end of three years. An appointed member shall not be eligible to serve continuously for more than three years but shall be eligible for reappointment if he has not served immediately preceding his reappointment.

"(b) The Surgeon General is authorized to utilize the services of any member or members of the Council in connection with matters related to the work of the Service, for such periods, in addition to conference periods, as he may determine.

"(c) Each member of the Council, other than the ex officio member, while attending conferences or meetings of the Council or while otherwise serving at the request of the Surgeon General, shall be entitled to receive compensation at a rate to be fixed by the Administrator, but not exceeding $25 per diem, and shall also be entitled to receive an allowance for actual and necessary traveling and subsistence expenses while so serving away from his place of residence.

"SEC. 5. The National Advisory Mental Health Council is authorized—

"(a) to review research projects or programs submitted to or initiated by it relating to the study of the cause, prevention, or methods of diagnosis and treatment of neuropsychiatric disorders, and recommend to the Surgeon General, for prosecution under section 3 of this Act, any such projects which it believes show promise of making valuable contributions to human knowledge with respect to the cause, prevention, or methods of diagnosis and treatment of neuropsychiatric disorders;

"(b) to collect information as to studies which are being carried on in the United States or any other country as to the cause, prevention, and methods of diagnosis and treatment of neuropsychiatric disorders, by correspondence or by personal investigation of such studies, and with the approval of the Surgeon General make available such information through the appropriate publications for the benefit of health and welfare agencies and organizations (public or private), physicians, or any other scientists, and for the information of the general public;

"(c) to review applications from any university, hospital, laboratory, or other institution or agency, whether public or private, or from individuals, for grants-in-aid for research and demonstration projects relating to neuropsychiatric disorders, and certify to the Surgeon General its approval of grants-in-aid in the cases of such projects which show promise of making valuable contributions to human knowledge with respect to the cause, prevention, or methods of diagnosis or treatment of neuropsychiatric disorders;

"(d) to review applications from any public or other nonprofit institution for grants-in-aid for training and instruction in matters relating to the diagnosis, prevention, and treatment of neuropsychiatric disorders, and certify to the Surgeon General its approval of such applications as it determines will best carry out the purposes of this Act;

"(e) to recommend to the Surgeon General for acceptance conditional gifts pursuant to section 501 of the Public Health Service Act for carrying out the purposes of this Act; and

"(f) to make recommendations to the Surgeon General with respect to carrying out the provisions of this Act.

"SEC. 6. The Surgeon General shall recommend to the Administrator acceptance of conditional gifts, pursuant to section 501 of the Public Health Service Act, for study, investigation, or research into the cause, prevention, and methods of diagnosis and treatment of neuropsychiatric disorders, or for the acquisition of grounds or for the erection, equipment, or maintenance of premises, buildings, or equipment of the Institute, only after consultation with the National Advisory Mental Health Council. Donations of $50,000 or over in aid of research under this Act may be acknowledged by the establishment within the Institute of suitable memorials to the donors.

"SEC. 7. (a) To enable the Surgeon General to carry out the purposes of this Act with the exception of section 8, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1946, the sum of $10,000,000 and for each fiscal year thereafter a sum sufficient to carry out such purposes.

"(b) For each fiscal year, the Surgeon General, with the approval of the Administrator, shall determine the total sum from the appropriation under subsection (a) which shall be available for allotments to States. He shall, in accordance with regulations prescribed by him with the approval of the Administrator, from time to time, make allotments from such sums to those States for plans which have been approved under this section.

"(c) The Surgeon General shall from time to time certify to the Secretary of the Treasury the amounts to be paid to each State from the allotments to such State. Upon receipt of such certification, the Secretary of the Treasury shall, prior to audit or settlement by the General Accounting Office, pay in accordance with such certification.

"(d) The moneys so paid to any State shall be expended solely in carrying out the purposes for which the grant is made and in accordance with plans presented by the health authority of such State and approved by the Surgeon General. The Surgeon General shall not approve any such plan unless it provides for expenditure thereunder, from funds of the State or from funds of the State and its political subdivisions, of such amounts as may be determined in accordance with regulations prescribed by the Surgeon General with the approval of the Administrator.

"(e) Whenever the Surgeon General, after reasonable notice and opportunity for hearing to the health authority of the State, finds that there is a failure to comply substantially with either—

"(1) the provisions of this section;

"(2) the plan submitted under subsection (d); or

"(3) the regulations prescribed under section 10 (c) with respect to this section;

the Surgeon General shall notify such State health authority either that further payments will not be made to the State under this section (or in his discretion that further payments will not be made to the State under this section for activities in which there is such failure), until

he is satisfied that there will no longer be any such failure. Until he is so satisfied the Surgeon General shall make no further certification for payment to such State under this section, or shall limit payment to activities in which there is no such failure.

"(f) All regulations and amendments thereto prescribed under section 10 (c) with respect to grants to States under this section shall be made after consultation with a conference of the State health authorities. Insofar as practicable, the Surgeon General shall obtain the agreement of the State health authorities prior to the issuance of any such regulations or amendments.

"SEC. 8. There is hereby authorized to be appropriated a sum not to exceed $4,500,000 for the erection and equipment, for the use of the Institute in carrying out the provisions of this Act, of suitable and adequate hospital buildings and facilities, and of suitable and adequate laboratory buildings and facilities. The Federal Works Administrator is authorized to acquire, by purchase, condemnation, donation, or otherwise, a suitable and adequate site or sites, selected on the advice of the Surgeon General, in or near the District of Columbia for such buildings and facilities, and to erect thereon, furnish, and equip such buildings and facilities when funds are made available. The amount authorized to be appropriated ih this subsection shall include the cost of preparation of drawings and specifications, supervision of construction, and other administrative expenses incident to the work: *Provided*, That the Federal Works Agency shall prepare the plans and specifications, make all necessary contracts, and supervise construction.

"SEC. 9. (a) Sums appropriated to carry out the purposes of this Act (except section 8) may be expended in the District of Columbia for personal services, stenographic recording and translating services, by contract if deemed necessary, without regard to section 3709 of the Revised Statutes; traveling expenses (including the expenses of attendance at meetings when specifically authorized by the Surgeon General); rental, supplies and equipment, purchase and exchange of medical books, books of reference, directories, periodicals, newspapers, and press clippings; purchase, operation, and maintenance of motor-propelled passenger-carrying vehicles; printing and binding (in addition to that otherwise provided by law); pay, allowances, and traveling expenses of commissioned officers and other personnel engaged in activities authorized by this Act; and for all other necessary expenses in carrying out the provisions of this Act.

"(b) Persons who are not citizens may be employed pursuant to subsection (g) of section 3 and may be appointed to fellowships pursuant to subsection (h) of that section. Unless otherwise specifically provided, any prohibition in any other Act against the employment of aliens, or against the payment of compensation to them, shall not be applicable in the case of persons employed or appointed pursuant to such subsections.

"SEC. 10. (a) There are hereby authorized to be appointed in the Public Health Service, in accordance with applicable law, such commissioned officers as may be necessary to aid in carrying out the provisions of this Act.

"(b) This Act shall not be construed as superseding or limiting (1) the functions of the Surgeon General or the Service under any

other Act, or of any other officer or agency of the United States, relating to the study of the prevention, diagnosis, and treatment of neuropsychiatric disorders; or (2) the expenditure of money therefor.

"(c) This Act shall be administered by the Surgeon General under the supervision and direction of the Administrator. The Surgeon General with the approval of the Administrator is authorized to make such rules and regulations as may be necessary to carry out the provisions of this Act.

"(d) As used in this Act, the term 'State' means a State or the District of Columbia, Hawaii, Alaska, Puerto Rico, or the Virgin Islands."

War Office of Psychiatric Social Work Continued as Aid to Mental Health and Rehabilitation of Service Men

Psychiatric social work has proved such a valuable resource to Selective Service and to the mental-health services of the armed forces that a projected discontinuance of the War Office of Psychiatric Social Work has been averted by securing additional financing and the work has been assured for another year.

Need for intelligent rehabilitation was emphasized in a letter that President Roosevelt wrote recently to Secretary of War Stimson:

"My dear Mr. Secretary:

"I am deeply concerned over the physical and emotional condition of disabled men returning from the war. I feel, as I know you do, that the ultimate ought to be done for them to return them as useful citizens—useful not only to themselves, but to the community.

"I wish you would issue instructions to the effect that it should be the responsibility of the military authorities to insure that no overseas casualty is discharged from the armed forces until he has received the maximum benefits of hospitalization and convalescent facilities which must include physical and psychological rehabilitation, vocational guidance, pre-vocational training and resocialization.

Very sincerely yours,
Franklin D. Roosevelt."

The war office, stimulated by an officially recognized need for its particular function, will continue in 1945 as a joint project of The National Committee for Mental Hygiene and the American Association of Psychiatric Social Workers.

Announcement has been made that Mrs. Elizabeth H. Ross, secretary of the war office of the association, has been appointed a consultant to the surgeon general of the army, bringing a more direct relationship between psychiatric social workers and the army, through the division of consultants in neuropsychiatry. Both neuropsychiatry and psychiatric social work have been utilized as important resources in the army as they have also been in Selective Service. The army has established services in conjunction with military psy-

chiatry in station, general, and neuropsychiatric hospitals, in consultation services in rehabilitation centers, in convalescent and reconditioning facilities, and in redistribution centers. The army is using its own enlisted personnel, both men and Wacs, in conjunction with psychiatry.

As secretary of the War Office of Psychiatric Social Work, Mrs. Ross will continue her work, not only with military authorities, but with civilian agencies concerned with the problems of war, such as Selective Service, the Veterans Administration, and the American Red Cross.

Officials of the two organizations now sponsoring the work welcomed the opportunity to formalize a long-standing close working relation between them, according to Dr. Stevenson, Medical Director of The National Committee for Mental Hygiene, and Miss Moore, President of the American Association of Psychiatric Social Workers.

Assured that the military authorities in this war need the assistance of trained psychiatric social workers to make effective the work of army psychiatrists by preparing case histories and helping in the treatment of psychiatric casualties, the office of the association has concentrated on helping to find within army ranks those who had such training and ability in civilian life.

Simultaneously, the office has been concerned with promoting the standing of such workers in the armed services, and with recruiting the greatest possible number of new, qualified workers into the field of psychiatric social work to meet future needs.

Developments in Psychiatric Nursing

The following report on recent developments in psychiatric nursing has been received from Miss Mary E. Corcoran, Advisor in Psychiatric Nursing, Mental Hygiene Division, U. S. Public Health Service:

> "*U. S. Army Nurse Corps.*—Courses in neuropsychiatric nursing are now in operation in five service commands. These offer a three-month, on-the-job training course for graduate nurses. Enrollment is made up of army nurses who volunteer for the course, and a certificate is awarded each on completion of the course. The hospitals at which the courses are presently being offered are: Cushing General Hospital, Framingham, Massachusetts; Mason General Hospital, Brentwood, Long Island, New York; Kennedy General Hospital, Memphis, Tennessee; Fitzsimons General Hospital, Denver, Colorado; McCloskey General Hospital, Temple, Texas. Courses will be established in other service commands in the near future.
>
> "*U. S. Navy Nurse Corps.*—During the year the navy has maintained postgraduate instruction in psychiatric nursing at St. Elizabeths Hospital. Ten nurses are assigned to this detail for four-month periods. In addition to nurse education, Waves and corpsmen are given instruction in the care of mental patients.

"*U. S. Veterans Administration.*—Affiliations in psychiatric nursing have been established, and are being conducted, in Veterans facilities located at Murfreesboro, Tennessee; Sheridan, Wyoming; and Tuskegee, Alabama. Tuskegee is for Negro student nurses. The courses at Tuskegee and at Sheridan are for three months; at Murfreesboro, students come for two months.

"*U. S. Public Health Service.*—The U. S. Public Health Service hospitals at Lexington, Kentucky, and Fort Worth, Texas, are conducting affiliate courses for student nurses in local hospitals. At Lexington the course has been of nine weeks' duration, but beginning February, 1945, it will be lengthened to twelve weeks. The course at Fort Worth is of eight weeks' duration.

"The public-health nurses in the field show increasing interest in mental hygiene. During the year, consultation service has been requested on several occasions.

"A course in psychiatric nursing is in operation at the Ypsilanti State Hospital, Ypsilanti, Michigan. A well-rounded program has been prepared and students are benefiting by their experience. Nurses who have completed their postgraduate work at Catholic University, Washington, D. C., and at the University of Minnesota are filling positions for which they were prepared."

Veterans Rehabilitation Center Established in Chicago

Announcement has been made of the establishment of a veterans rehabilitation center in Chicago, at 2449 West Washington Boulevard, to be operated jointly by the Department of Public Welfare, State of Illinois, and the Illinois Veterans Service. The present floor plan of the Washington Boulevard Hospital has been utilized. The operating rooms, wards, some single rooms, and the hospital grounds have been refurnished and equipped for purposes of occupational therapy, recreation, and so on.

Full-time specialists, assisted by volunteers, supervise the projects. At present 100 veterans are under treatment. This number can be doubled by increasing the personnel.

Decalogue for Relatives of Returning Service Men

The following decalogue for relatives and friends of returning service men is taken from the pamphlet with the double title *When He Comes Back* and *If He Comes Back Nervous,* prepared by Dr. Thomas A. C. Rennie and Dr. Luther E. Woodward, of the Division on Rehabilitation, The National Committee for Mental Hygiene:[1]

"1. *Love him and welcome him.* Show him how glad you are to have him back, and if he has handicaps let him know that this makes no difference in your love and esteem. If you show real pleasure in

[1] Copies of the pamphlet can be obtained from The National Committee for Mental Hygiene. Single copy 15 cents; twenty-five or more copies, 10 cents each; one thousand copies, 80 dollars.

his presence, he will know he is still loved and wanted and will quickly lose some of his fear and feel more comfortable. Welcome him in your own quiet way. Don't call a family reunion, which would expose him to the curiosity of every one. He will get around to Uncle Jim and Aunt Sue in due time and will like it much better that way.

"2. *Listen well,* that is, listen as understandingly as you know how, and *don't pry* into his personal experiences while in the service. To ask him about the new lands he has visited and the folkways of the people in these new lands is quite in order, but questioning him about his training and combat experience and the reasons for his discharge are to be avoided. If he chooses to talk about these things, it will be helpful to him if you listen well.

"3. *Face the reality of the disability,* if he returns with one, whether it be a weak heart, impaired hearing, loss of a hand, or whatever. *Don't try to ignore it.* As one columnist has put it, 'I'd be as mad as a prodded wasp if I came home without an arm or a leg, and no one paid any attention to it and went on behaving nice and normal.' *But don't magnify it. Focus on what is left, not on what is lost.*

"4. *Treat him as an essentially normal, upstanding, competent person, not as an invalid.* More than anything else most men fear being oversympathized with and having too much done for them by their families. They do not consider themselves 'washed up' and they don't want to be treated as though they were. If they are treated as well and competent, most of them will quickly prove that they are. Avoid doing too much for your returned service man. Rather seek his help with jobs that will help you or others.

"5. *Commend his efforts and successes and ignore the slips.* This is good policy with husbands, wives, or children—in fact, with anybody at any time—but it is especially needed in dealing with men who come back feeling somewhat insecure. We are all so made that we try to do our best if our virtues and successes are acknowledged, but we are apt to repeat our faults if we are nagged about them.

"6. *Expect him to be different in some ways.* If he was very young when he went away, he is sure to have grown up a lot. He may have grown ten years in two. Because of nerve-racking experience in the armed forces and his worry about getting into the swing of civilian living, he may be more easily irritated and annoyed; he may tease you in a way he never did before, or he may appear quieter or more serious. We who have stayed at home may have changed also. In fact, one of the most common complaints made by returning service men is that the folks at home are different. *Take time to get acquainted again and to find ways of getting along together.* This is particularly true of younger men and their young wives or sweethearts.

"7. *Allow him time and freedom in getting acquainted with the old places and in reëstablishing his old contacts.* When he comes back he may have an acute need to do just this. No one can predict the order in which he will want to renew old acquaintances, but if he is like most men, he will want to make such contacts one at a time, and not be drawn into family reunions and big parties.

"8. *Create an atmosphere of expectancy: encourage him to take up his favorite hobby or sport, to go back to work as soon as he is able, and to lead a normal social life; but avoid pushing or regulating him,*

for top-sergeant methods won't work at home. Especially if he has some physical handicap or some mild nervous condition, he will tend to take on gradually the tone of the people he lives with. If you have a hopeful outlook, he is likely soon to share your view.

"9. *Get professional help if it is needed. Don't just muddle through.* The medical divisions of the armed forces give excellent service in restoring as fully as possible the health of men who are wounded, but the restoration may be incomplete when he returns in case of nervousness, severe wounds, or some other ailments which are long drawn out. In fact, many men are discharged during convalescence, so that they may have the invigorating benefits of home, friends, and a congenial job. Professional help should be obtained—problems should not be allowed to drag on. Most nervous ailments respond well to psychiatric treatment. Social workers can help with family and social adjustments. Vocational counselors can aid in the choice of training or employment.

"10. *Let your own faith and beauty of spirit be your chief stock in trade.* He needs chiefly an encouraging onlooker and a traveling companion. He has to make his own way, but he will get on faster if he knows you are betting on him and if he sees that you enjoy even his small successes."

Did You Know That—

Only 32 of the 1,307 accredited basic schools of nursing in the United States are found in mental hospitals and 17 of these are in New York State?

Approximately 27,000 men are being discharged each month from the armed services for various types of neuropsychiatric disorder? This represents about 45 per cent of the medical discharges.

Eight out of every ten men discharged from the armed services for neuropsychiatric reasons require some type of psychiatric treatment?

The National Child Labor Committee reports that the young people who dropped out of school to go to work during the war will present a major post-war educational problem? The mental health of these young people is frequently lowered as a result of this effort.

New Rochelle Child Guidance Clinic Marks Completion of Three Years of Work

On February 14 the Child Guidance Clinic of New Rochelle, Westchester County, New York, an account of which was published in the April, 1944, issue of Mental Hygiene, celebrated the completion of its third year of service to children and parents in New Rochelle, Pelham, Larchmont, and Mamaroneck. The celebration took the form of a meeting attended by more than sixty-five members and guests of the Woman's Conference of the Westchester Society of

Ethical Culture. Mrs. Walter Jacobs, who was president of the conference at the time the clinic was organized, was chairman of the program; and Dr. Geraldine Pederson-Krag, child psychiatrist, and Willis Thomson, Principal of Isaac E. Young High School and chairman of the clinic's board of governors, were the speakers. Dr. Pederson-Krag explained the program of the clinic, and Mr. Thomson described the types of child that the school should recognize as behavior problems in need of such service as the clinic offers. A check for $1,000 for continuation of the clinic was presented to Mr. Thomson, as chairman of the board of governors, by Mrs. Lawrence Ley, President of the Woman's Conference.

Commissioner William J. Ellis Dies

Welfare circles were shocked to learn of the death, at the age of fifty-three, of William J. Ellis, Commissioner of the New Jersey State Department of Institutions and Agencies, at his home in Trenton, New Jersey, on March 11.

Commissioner Ellis had spent more than twenty-five years in state service and was nationally known for his work in sociology and education. A graduate of Hobart College, where he also received his master's degree, he began his career as psychologist in the New Jersey Department of Institutions and Agencies in 1919, after serving two years in the U. S. Army as second lieutenant. In 1921, he became director of the division of education and classification, and in 1926 he was appointed acting commissioner and then commissioner of the department.

One of his first steps was to establish a classification system that became a model for other states. His emphasis was always on preventive work and upon what he considered the primary purpose of the institutions in his department—"the restoration of the handicapped to a normal life in the community as quickly as possible, consistent with their own welfare and the well-being of their neighbors."

In a statement issued after his death, Governor Walter E. Edge said of him:

"He, more than any one else, was responsible for the high regard in which the New Jersey penal and correction system is held throughout the nation.

"Always progressive, Commissioner Ellis devoted his life to the constant improvement of penal and hospital administration, child welfare, and the rehabilitation of parolees. As such, he was recognized as an outstanding authority in his field."

Dr. Guthrie Goes to Connecticut

Dr. Henry Riley Guthrie, who has been Assistant Superintendent at St. Elizabeths Hospital and professor of clinical medicine at Georgetown University School of Medicine, Washington, D. C., has resigned both positions as of February 1, 1945 and has been appointed Superintendent of the Norwich (Connecticut) State Hospital. Dr. Guthrie was graduated from the University of Tennessee College of Medicine in 1921. Prior to being at St. Elizabeths Hospital, he was connected with the Boston Psychopathic Hospital.

Canadian Appointments

Major George B. Chisholm, Director-General of Medical Services for the Canadian Army, and George F. Davidson, Director of the Canadian Welfare Council, have been appointed deputy ministers in the department of national health and welfare. This department was set up as a separate unit during the last session of parliament.

Institute on Reading Instruction

The Reading Clinic Staff, School of Education, The Pennsylvania State College, State College, Pennsylvania, is sponsoring a one-week institute on reading problems in elementary and secondary classrooms. "Differentiated Reading Instruction" will be the general theme of the institute, which will extend from June 25 to 29. One day will be given to each of the following topics: reading readiness, discovering reading levels and needs, children's literature, developing basic reading skills and abilities through the use of current-events materials, and approaches to differentiated reading instruction. These topics will be developed by means of lectures, demonstrations, and informal discussions.

The program has been differentiated to meet the needs of elementary, secondary, special-class, reading, and speech teachers and supervisors. In addition, special sessions will be conducted for supervisors, administrators, and school psychologists. The program has been planned in coöperation with the following national organizations: the American Speech Correction Association, the Association for Childhood Education, the Department of Elementary School Principals, the Department of Supervisors and Curriculum Directors.

The meetings for elementary-school teachers will be under the direction of Dr. E. A. Betts and Miss Carolyn M. Welch: those for secondary teachers, under Miss Carol Hovious. Speakers and demonstrators include Dr. Marian Anderson, Mrs. May Lamberton Becker, Miss Ruth Cunningham, Miss Phyllis Fenner, Dr. Catherine Geary, Dr. William S. Gray, Miss Eleanor Johnson, Dr. Victoria Lyles,

Miss Eva Pinkston, Dr. Sarah I. Roody, Dr. Rachael Salisbury, Miss LaVerne Strong, and others to be announced later.

Tentative programs and transportation schedules may be obtained by writing to Miss Betty J. Haugh, secretary of the reading clinic.

1945 Program of Cleveland Mental Hygiene Association

The First Annual Meeting of the Cleveland Mental Hygiene Association was held on January 16, 1945. An address on "Better Mental Health for Ohio Citizens" was given by Dr. Frank F. Tallman, Commissioner of Mental Diseases, Ohio State Department of Public Welfare; and on behalf of the association, scrolls were presented to Mr. H. H. Griswold, Dr. Louis J. Karnosh, and Dean Leonard W. Mayo, in recognition of their distinguished work as members of the Governor's Committee on the Mental Health Program for Ohio.

The association has planned the following program for 1945:

"1. Foster a rehabilitation program, including the establishment of clinics, for men discharged from the armed services as psychiatric casualties.

"2. Promote the development and extension of psychiatric clinics and services to meet over-all community needs in the Cleveland area.

"3. Seek to make psychiatric services available to larger numbers of vocationally handicapped persons, and to coördinate treatment facilities with the state rehabilitation program.

"4. Develop, in coöperation with other agencies, adequate programs of case finding of individuals who need psychiatric treatment.

"5. Stimulate efforts for the recruitment and training of psychiatric personnel needed to overcome the shortages in the Cleveland area.

"6. Establish the initial phases of a long-range program of mental-health education in the public schools.

"7. Function as a center of information for individuals and agencies in mental-hygiene matters.

"8. Serve as a consulting and coördinating agency to other agencies and organizations with respect to the mental-health aspects of their programs.

"9. Continue to undertake educational programs in mental hygiene through the radio, newspapers, exhibits, motion pictures, and the distribution of literature.

"10. Conduct research in community needs and problems in the mental-hygiene field.

"11. Encourage the organization and extension of mental-health programs in industry.

"12. Promote the adoption of a modern mental-health program in Ohio."

American Association of Psychiatric Social Workers Cancels Annual Meeting

In compliance with the recommendations of War Mobilization Director Byrnes, the American Association of Psychiatric Social

Workers will not hold an annual meeting this year. As yet no plans have been worked out for local programs. This is the year for a new administration. Elections which ordinarily take place at the annual meeting will be held by mail. Through the *News-Letter* the association will try to publish material that otherwise might have been presented on its program at the National Conference.

Radcliffe College Offers Fellowship in Genetics or Mental Health

Radcliffe College is offering for the academic year 1945–46 the Helen Putnam Fellowship for Advanced Research in the field of genetics or of mental health.

The fellowship, which carries a stipend of $1,900, will be awarded annually, beginning with October 1, 1945, for an eleven-month period, with the possibility of a renewal for a similar period. Appointments will be limited to mature women scholars who have gained their doctorate or possess similar qualifications and who have research in progress. All normal laboratory facilities will be provided to the holder of the fellowship.

The committee on award includes: President W. K. Jordan, of Radcliffe, and the following members of the Harvard University Faculty: Arlie V. Bock, M.D., professor of hygiene; Stanley Cobb, M.D., professor of neuropathology and Psychiatrist-in-Chief at the Massachusetts General Hospital; Alden B. Dawson and Leigh Hoadley, professors of zoölogy; Karl Sax, professor of botany; and Edwin B. Wilson, professor of vital statistics.

Neuropsychiatric Clinic to Be Created at Rochester Medical School

(From the *Journal of the American Medical Association*, February 24, 1945)

The establishment of a neuropsychiatric clinic at the University of Rochester School of Medicine and Dentistry, Rochester, has been made possible by a gift of securities to the university by Mrs. Helen W. Rivas, of New York City and Le Roy, N. Y. Of the total gift a portion is designated for construction and equipment of a building to house the clinic as a unit of the School of Medicine and Dentistry and of Strong Memorial Hospital. A trust fund has been set up to operate and maintain the clinic. The new unit will be constructed as soon as practicable in view of present building conditions. In the meantime a committee of the medical-school faculty will survey the field throughout the country to select a man to head the clinic so that he may participate in preparing the plans for the physical plant and the staff organization. It is contemplated

that the clinic will be used for the study and care of persons having functional nervous disorders rather than for those with extreme mental ailments. Provision will be made for ample laboratory space for active research and investigation. It is planned to have beds for from 50 to 60 inpatients, and extensive use of the clinic for ambulatory patients is anticipated. Income from the endowment fund set up for the clinic will be paid to the university and accumulated to finance the project.

Menninger Institutions Reorganized

(From the *Journal of the American Medical Association*, February 24, 1945)

At a recent special meeting of the stockholders of the Menninger Sanitarium corporation, Topeka, a resolution was approved to dissolve the corporation as of next June 30 and to transfer its assets to the Menninger Foundation. The reorganization would promote the expansion program entailing more than $1,250,000 and would, when permissible, allow a long-considered consolidation of activities in education, treatment, and research. The transfer in assets will involve buildings, equipment, grounds, and other facilities of the clinic on West Sixth Street totaling $325,000, of which $200,000 will be a personal contribution of Drs. Charles F., Karl A., and William C. Menninger and their colleagues. According to the Topeka *State Journal*, an earning capacity of between 70 and 80 thousand dollars annually, along with the good will and prestige of the organization, which has completed twenty-five years, will be additional benefits. Treatment of a larger number of patients, both adults and children, without regard to their financial status, will be a major aim of the foundation, for which a psychiatric-hospital unit costing $750,000 is contemplated. Additional buildings trebling the capacity of the Southard school would cost $250,000, and a psychosomatic hospital unit for correlation of psychiatric and medical studies were projected at $150,000. A fund of $100,000 a year would permit low-cost treatment for patients with small incomes. Estimates for postgraduate education, including training for young psychiatrists, physicians returning from military service, nurses, teachers, and others, were placed at $105,000; for research $149,000; for scholarships and promising children $30,000; and for publications $5,000. The Menninger project is an original partnership of the father, Dr. Charles Frederic Menninger, and his two sons and includes a hospital on a 30-acre tract, the Southard school established in 1925 for the treatment of children, a library to further teaching and research, and a department of psychology established by Junius F. Brown, Ph.D., professor

of psychology, University of Kansas, Lawrence, and continued by David Rapaport, Ph.D. The Menninger Foundation was organized in 1941.

Committee to Study Health Problem to Be Appointed in West Virginia

Legislative Bulletin No. 2 of the West Virginia State Medical Association, dated February 20, states that final action on House Concurrent Resolution No. 4, providing for the appointment of an interim committee to make an over-all study of health conditions in West Virginia, was taken by the House on February 15, when minor Senate amendments were accepted and the resolution adopted. The vote in both branches was unanimous. The study will be made by an interim committee composed of five members from the Senate and five from the House of Delegates and an advisory committee of not to exceed twenty-five persons to be appointed by the governor, five of whom shall be licensed doctors of medicine practicing in West Virginia.

State Society News

Hawaii

On January 1, the Hawaii Territorial Society for Mental Hygiene, now in its third year of existence, brought out the first number of its bulletin, *Better Mental Health for Hawaii.* The bulletin, whose subscription price is included in membership dues, is to be issued quarterly, to keep the members of the society in touch with its activities and with mental-hygiene developments in general.

Minnesota

A joint dinner meeting of the Minnesota Mental Hygiene Society and the American Association of Social Workers, held on January 17, was attended by one hundred members of the two associations. Mrs. Carl Lefevre, executive secretary of the mental-hygiene society, reported on the two-day annual meeting of The National Committee for Mental Hygiene; and local aspects of the problem of rehabilitating returning veterans were discussed by James Hines, Director of V.I.R.O., Minneapolis; William Nelson, V.I.R.O., St. Paul; Leigh Harden, Veterans Bureau at the university; O. A. Pearson, Chairman of the Executive Committee of the Minneapolis V.I.R.O.; and representatives of labor.

Vermont

The January *News Letter* of the Vermont Society for Mental Hygiene announces that the society's spring meeting will be held in Middlebury in late April or early May. Dr. Elizabeth Kundert, state psychiatrist and chairman of the society's program committee, is arranging a program centering about the subject of the mental-health aspects of alcoholism.

Announcement is made also that the society will sponsor a meeting for teachers at the time of the Vermont Education Association's convention in October. Professor Sara Hildreth, of the University of Vermont, is chairman of the committee in charge.

The *Vermont Social Welfare News* has agreed to allow space in each issue for a section from the mental-hygiene society. The column will be edited by the society's secretary, Miss Dorothy Smithson, of the Vermont Association for the Crippled.

Through the kindness of the League of Women Voters, the society has been able to make available to its members abstracts of a report prepared for its ways and means committee by Dr. Frederick C. Thorne, of Brandon State School, on "The Problem of Mental Disease in Vermont." Dr. Thorne presents some startling figures on the incidence of mental disease and mental defect in Vermont, discusses the present facilities of the state for meeting the problem, and outlines a broad program of prevention.

Washington

On February 6, 7, and 8 the Washington Society for Mental Hygiene sponsored a series of lectures by Lieutenant Robert A. Sutermeister on "The Promotion of Mental Hygiene Through Personnel Administration." The subjects of the three lectures were, respectively, "The Growing Emphasis on Human Relations," "Everyday Problems of Supervision," and "Management's Approach to the Individual." Lieutenant Sutermeister, formerly Personnel Director of Pacific Huts, Inc., is at present serving as Personnel Relations Officer, Naval Supply Depot, Seattle.

New Publications

The National Committee for Mental Hygiene announces that the following material is now available at its office, 1790 Broadway, New York 10, N. Y.:

Reprints of the various articles on rehabilitation and the veteran published in Mental Hygiene, January, 1945.

Two bibliographies prepared by the Division on Rehabilitation of

The National Committee for Mental Hygiene, one on "The Mental Hygiene of Industry," for executives, personnel managers, counselors, industrial physicians, and so forth; the other on "Psychiatric and Mental Hygiene Aspects of Civilian Rehabilitation." Price, 20 cents each.

The National Music Council, a nonprofit membership corporation of New York City, has brought out in pamphlet form the report of a survey made by them on "The Use of Music in Hospitals for Mental and Nervous Diseases." The survey was conducted by means of a questionnaire prepared with the collaboration of Dr. Samuel W. Hamilton, of the United States Public Health Service, and Dr. Willem van de Wall, author of *Music in Institutions.* This questionnaire was sent to 341 hospitals for mental and nervous diseases. Two hundred and nine replies were received, and were sent to Dr. Hamilton and Dr. van de Wall for evaluation. The present pamphlet gives their reports and comments. The pamphlet can be secured at the price of 15 cents a copy from the National Music Council, 338 West 89th Street, New York 24, N. Y.

An attractive little pamphlet describing an experiment in conducting a class in soap sculpture for patients in a mental hospital has been issued by the Procter and Gamble Company, under the title *The Mental Ward Becomes a Studio.* The experiment was suggested by Ernest Bruce Haswell, the sculptor, author of the pamphlet, and the company was interested enough to undertake to sponsor the project, feeling that "a hobby proved successful with a vast number of people, from all walks of life and of all degrees of artistic ability, could well be developed into a most effective occupational craft for the treatment of mental and nervous disorders."

As the foreword of the pamphlet points out, "Haswell approached his experiment solely from the standpoint of an artist and teacher and his report does not attempt to assay the therapeutic merits of soap sculpture—that will be the function of a skilled psychiatrist. Haswell's report rather gives an account of the teaching techniques he employed, the problems he encountered, and—from the non-technical point of view—the beneficial effect working with sculpture had on the members of his class."

Copies of the pamphlet can be obtained by writing to the Procter and Gamble Company, Cincinnati, Ohio.

The U. S. Office of Education announces the publication of two new leaflets in the "Planning Schools for Tomorrow" series—No. 72, *Pupil Personnel Service for All Children,* and No. 74, *Needs of Exceptional Children.*

Epilepsy—The Ghost Is Out of the Closet is the title of a pamphlet by Herbert Yahraes recently issued by the Public Affairs Committee, 30 Rockefeller Plaza, New York City. Causes and diagnostic methods are discussed, modern methods of treatment are outlined, and an encouraging survey of industrial opportunities is given. The pamphlet is distributed by the Public Affairs Committee at 10 cents a copy.

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